Good

Surrey and Borders Partnership NHS Foundation Trust

Wards for people with learning disabilities or autism

Quality Report

The Deacon Unit
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXXZ3	Deacon Unit	The Deacon Unit	KT19 8QJ

This report describes our judgement of the quality of care provided within this core service by Surrey and Borders NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Surrey and Borders NHS Foundation Trust and these are brought together to inform our overall judgement of Surrey and Borders NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We rated wards for people with learning disabilities or autism as **good** overall because:

The unit had a bespoke calming suite, which was adapted specifically to suit the needs of the client group, and had its own operational policy to ensure it was managed safely. The staff team from The Deacon unit had been heavily involved in the development of this area and in the design and manufacture of some of the furnishings so it could be specifically tailored to the nature of some of the clients that may use the service.

The unit had a cohesive and effective relationship with the Intensive Support Service (ISS), which meant that if additional staff were required they were able to cross-cover. When the unit had fewer patients, the surplus staff were employed within the ISS team to support people in the community. This arrangement also worked in the opposite way when required. This meant there were only two shifts in the three months preceding the inspection that were not covered.

The unit followed the NHS England "stopping the overmedication of people with a learning disability" agenda (STOMP LD). This is a three-year agenda started in 2016 which is designed to make sure people get the right medicine if they need it and that people get all the help they need in other ways as well.

Risks to physical health were identified and managed effectively by trained staff. The service used a standardised system called Modified Early Warning System (MEWS) to monitor and record the physical health of patients.

Staff carried out a range of assessments with patients on admission to the unit and throughout their care and treatment. These included, but were not limited to, physical health assessment, medication assessment, functional behaviour assessment and analysis.

Carers felt involved in contributing to patient's care plans. Carers told us they felt staff knew the patients very well. Carers were invited to attend care programme approach meetings, and were aware of plans and goals for discharge.

Staff expressed a caring approach when they were talking about the patient group and it was clear there was an understanding of the patients' individual presenting needs and how best to support them on a daily basis.

As part of the transforming care programme for people with learning disabilities, the service was discharge oriented. Staff were committed to achieving a sustained reduction in the number of patients admitted to the wards.

Records shown to us by the trust showed that in the 12 months leading up to the inspection the service had received no complaints and had received multiple compliments from family members and carers.

There was high staff morale across the clinical team. All the staff we spoke with were enthusiastic and proud about their work and the care they provided for patients on the unit. The clinical team were motivated to inspire and support staff to succeed. Staff described strong leadership on the ward and said that they felt respected and valued.

There was an effective incident feedback loop and ward staff were aware of outcomes from incidents that had occurred on the unit which had been discussed by the clinical team.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Good

We rated safe as '**Good**' for wards for people with learning disabilities or autism because:

- The unit had a bespoke calming suite, which was adapted specifically to suit the needs of the client group, and had its own operational policy to ensure it was managed safely. The staff team from The Deacon unit had been heavily involved in the development of this area and in the design and manufacture of some of the furnishings so it could be specifically tailored to the nature of some of the clients that may use the service.
- The unit had a cohesive and effective relationship with the Intensive Support Service (ISS), which meant if additional staff were required they were able to cross cover. When the unit had fewer patients the surplus staff were employed within the ISS team to support people in the community. This meant there were only two shifts in the three months preceding the inspection that were not covered.
- Staff applied well-structured proactive strategies to de-escalate or prevent patients' challenging behaviour. Reactive strategies were also clearly identified and gave step-by- step advice to staff regarding how to minimise the likelihood that challenging behaviour would escalate.
- Staff carried out risk assessments collaboratively between the patient, their family or carer, and the multidisciplinary team on admission and regularly throughout their care and treatment. This meant that risk was being assessed and regularly reviewed and care plans were put in place with the patient to minimise the risk happening again.
- Each patient had a specific care plan kept with the medication card in relation to each of their PRN medications (when required medications). This meant that staff were using PRN medication more consistently and only after a specific set of alternative interventions had been exhausted.

Are services effective?

Good

We rated effective as '**Good**' for wards for people with learning disabilities or autism because:

Summary of findings

- The unit had a weekly clinical review meeting that was effective and focused on sharing information, the patient's clinical treatment and reviewing the patient's progress. Staff from different disciplines demonstrated a mutual respect and the views of all professionals were well valued.
- The unit used electronic care plans on 'SystmOne. However, in addition to this the unit used a paper file called "my plan". These were adapted care plans that were easy to read and available in pictorial format. Patients were encouraged and empowered by staff to be fully involved in the planning of their care needs.
- The unit was following the NHS England "stopping the overmedication of people with a learning disability" agenda (STOMP LD).This is a three-year agenda started in 2016 which is designed to make sure people get the right medicine if they need it and that people get all the help they need in other ways as well.
- Risks to physical health were identified and managed effectively by trained staff. The service used a standardised system called Modified Early Warning System (MEWS) to monitor and record the physical health of patients.
- The unit had a full multidisciplinary team available, which worked across the Deacon unit and the Intensive Support Service, which included psychiatry, nursing and support workers, psychology, speech and language therapy and occupational therapy.
- Staff carried out a range of assessments with patients on admission to the unit and throughout their care and treatment. These included but were not limited to physical health assessment, medication assessment, functional behaviour assessment and analysis

Are services caring?

Good

We rated caring as '**Good**' for wards for people with learning disabilities or autism because:

- Carers felt involved in contributing to patients' care plans. Carers told us they felt staff knew the patients very well, they were invited to attend care programme approach meetings and were aware of plans and goals for discharge.
- Staff expressed a caring approach when they were talking about the patient group and it was clear there was an understanding of the patients' individual presenting issues and how best to support them on a daily basis.

Summary of findings

- Patients reported that when they came into the unit the team had discussed their medication and if appropriate how to reduce the medication regimes safely.
- Patients had an independent mental health advocate through "Advocacy In Surrey". We saw details of the service were displayed on all the wards and patients told us they were supported to access an advocate if they wished.

Are services responsive to people's needs?

Good

We rated responsive as '**good**' for wards for people with learning disabilities or autism because:

- As part of the transforming care programme for people with learning disabilities, the service was discharge oriented and committed to achieving a sustained reduction in the number of patients admitted to the wards.
- The unit was furnished to a good standard, in excellent repair and with high levels of cleanliness. Patients had the ability to personalise their bedrooms and were encouraged to put pictures of their family or things they like in painted frames on the wall. The overall effect of this was to make the bedroom more homely and familiar.
- Occupational therapy staff worked with patients to develop a variety of individual sessions that were based on the therapeutic value of the activities. Activity sessions were also co-ordinated to include the patients carrying out activities with their family members support..
- Information was clearly displayed on communal noticeboards on all the wards in an accessible and easy to read format.
- Records shown to us by the trust showed that in the 12 months leading up to the inspection the service had received no complaints and had received multiple compliments from family members and carers.

Are services well-led?

Outstanding

We rated well-led as '**outstanding**' for wards for people with learning disabilities or autism because:

- Staff were able to access a wide variety range of statutory and mandatory training to support them in their roles. In addition to this and due to the skills of the multidisciplinary team, staff had excellent opportunities to attend specialist training to support them in developing their practice and improve care and treatment outcomes for patients.

Summary of findings

- Staff had regular monthly supervision and felt well supported by their managers through the formal supervision structure. Staff also felt they could approach the management team for advice whenever they felt it necessary.
- There was an effective incident feedback loop and ward staff were aware of outcomes from incidents that had occurred on the unit which had been discussed by the clinical team.
- Staff were involved in a wide variety of national and local clinical audit programmes, research and peer review projects which were designed to improve and enhance the quality of service provided to patients.
- Staff expressed how much they enjoyed their work and the therapeutic relationships they built with patients. Staff were positive and optimistic about patients, and this was evident in the interactions we observed across the unit.
- There was high staff morale across the clinical team. All the staff we spoke with were enthusiastic and proud about their work and the care they provided for patients on the unit. The clinical team was motivated to inspire and support staff to succeed. Staff described strong leadership on the ward and said that they felt respected and valued.

Summary of findings

Information about the service

Surrey and Borders Borders Partnership NHS Foundation Trust provides health and social care services for people of all ages with mental ill health and learning disabilities in Surrey and North East Hampshire and drug and alcohol services in Surrey, Hounslow and Brighton. They also provide social care services for people with a learning disability in Croydon and Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder assessment services in Hampshire.

Surrey and Borders Partnership NHS Foundation Trust serves a population of 1.3 million.

Surrey and Borders Partnership NHS Foundation Trust was previously inspected in October 2014 and March 2016.

The Deacon Unit is a 10-bed specialist inpatient service for patients with a learning disability or autism. It is set in the grounds of St Ebba's. The unit opened on 24 January 2017.

Since the unit opened it has not had a CQC inspection, although the unit has been visited on one occasion by a Mental Health Act reviewer.

Our inspection team

The inspection team was led by James Whittle

The team that inspected wards for people with learning disabilities or autism comprised one inspector from the Care Quality Commission and one nurse specialist professional advisor. Both team members had expertise in learning disabilities and autism.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

This service had opened after the last comprehensive inspection of Surrey and Borders Partnership NHS Foundation Trust so had not been inspected prior to this date.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services including a summary of outcomes from Mental Health Act reviewers' inspection visits completed in the past year.

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with the ward manager and the service director

Summary of findings

- spoke with seven staff, including nurses, support workers, occupational therapists, psychologist, speech and language therapists and doctors
- spoke with four patients
- spoke with four relatives/carers
- reviewed all five patients' care records, including care plans, initial assessments, physical health monitoring, risk assessments
- reviewed all five medication charts
- attended and observed a clinical review meeting
- attended and observed a shift handover
- attended and observed a therapy group in the Oasis centre

looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with three out of the five patients They spoke very highly of the staff and the quality of care they received. They said staff were caring and supportive and they felt truly respected, involved and empowered to make decisions as individuals in the therapies and treatments offered to them.

The patients we spoke to knew their named nurse, their doctor and the manager of the unit. All said they had been involved in planning their care and were supported by staff to understand their care plans and were offered copies of their care plans. Patients told us they felt listened to and involved in the running of the service.

We spoke with four relatives/carers. Carers told us they felt staff knew the patients very well. Carers felt involved in contributing to patients' care plans, were invited to attend care programme approach meetings and were aware of plans and goals for discharge. Carers said that staff communicated well with them and they were kept well informed of every aspect of their relatives' care and treatment.

We saw the unit had received a number of compliments from patients, families and external stakeholders praising the care and support provided by staff to patients.

Patients and their carers were encouraged to share information about their likes and dislikes, interests and hobbies. This information was displayed in the bedrooms.

A survey called "your views matter" which asked questions about how the patients felt about staying at the Deacon Unit had been completed twice in the 12 months prior to the inspection. Although taken from a small sample of patients, the survey indicated that patients felt listened to and helped to make choices.

Good practice

- The Deacon Unit followed the NHS England "stopping the overmedication of people with a learning disability" agenda (STOMP LD).This is a three-year agenda started in 2016, which is designed to make sure people get the right medicine if they need it and that people get all the help they need in other ways as well. Patients had weekly medication reviews and the clinical team closely monitored the use of emergency "when required" medication. In addition they raised awareness within the team of non-drug therapies and practical ways of supporting people whose behaviour was seen as challenging.
- Patients had a specific care plan attached to the medication chart, which clearly identified when and why to consider the administration of PRN (as needed) medication, and how to follow up the patient if PRN was used. This meant that there was a safe, consistent approach to the management of as needed medication.
- The unit had developed a quality improvement plan to introduce the SBAR handover tool (Situation,

Summary of findings

Background, Assessment, Recommendation). We saw the SBAR tool used at a handover at which relevant and well-structured information was being handed over effectively between teams.

- The service had developed a quality improvement plan to improve the management of the MEWS scoring system (Modified Early Warning System) which is a tool designed to help monitor and assess patients' health to watch out for signs of a physical decline.

Surrey and Borders Partnership NHS Foundation Trust

Wards for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Deacon Unit	The Deacon Unit

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

Training in the Mental Health Act was mandatory for all staff. As of January 2018, 75% of staff had completed the training. This is less than the trust standard of 90%. It was noted this level is due to a reduction in course availability.

The staff we spoke with demonstrated a good knowledge and understanding of the Mental Health Act .

All staff were aware of the requirements for authorising section 17 leave and their role and responsibilities as escorts during leave for their patient groups.

Information was displayed on the ward noticeboards regarding the independent mental health advocate and how to contact them. In addition, information was available around the ward providing details on each of the relevant sections of the Mental Health Act and information about how to complain and who to complain to. All of the information was displayed in an easy to read accessible format that was created by the service.

There was information related to what should happen if a patient were to be discharged from the Mental Health Act, whilst they stayed at the hospital, in relation to their rights to leave the ward. This was available on a notice board near to the door.

We reviewed records of community access agreed with the consultant psychiatrist from the ward into the community. The arrangements of the community access that had been agreed were clearly documented.

When necessary staff supported patients to understand their rights in accordance with section 132 of the Mental Health Act. This was routinely recorded on System one, the patients' electronic care records.

Detailed findings

Patients' medicine charts had photographs of patients and when necessary T2 or T3 treatment authorisation certificates.

Staff at the service had access to the trust's Mental Health Act administration team for support and advice on admission and when needed. The Mental Health Act team oversaw renewals of detention under the Act, consent to treatment and appeals against detention.

Patients had access to mental health review tribunals and hospital managers' meetings and these were logged and recorded in care notes.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) enables people to make their own decisions wherever possible and provides guidance for decision making where people are unable to make decisions themselves. Staff we spoke with demonstrated a good understanding of the MCA.

We observed staff seeking informed consent from patients and these consent issues were discussed in the weekly clinical review meeting.

Staff held best interest meetings when patients lacked capacity to make decisions about certain aspects of their life or care and treatment. Staff clearly documented the outcome of the best interest decision in patients' care records.

All staff had completed training in the MCA and Deprivation of Liberty Safeguards (DoLS).

There was a trust policy on the MCA including DoLS which staff were aware of and could refer to.

The service provided information for the number of current DoLS applications they made for the Deacon Unit. Between January 2017 and January 2018, four DoLS applications were made. These had all followed the correct procedure of urgent authorisation followed by standard authorisation which were regularly tracked.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The ward's layout did not enable staff to observe most parts of the wards easily.The building was old and was listed; this limited the extent to which the building could be altered. This meant there were some restricted lines of sight across the ward but these were adequately mitigated by staff observation and patients being supported on higher observation levels. There were systems in place for staff to provide safe patient observations and this was well documented.
- Staff had identified ligature points using their hospital's screening tool and completed environmental ligature assessments annually. A ligature point is something which people can use to tie something to in order to strangle themselves. In addition, daily walk-around security checks and a weekly environmental check on the ward ensured a regular systematic approach to maintaining a safe environment. We reviewed a sample of these and saw that most identified risks were either rectified or managed against individual patient risk assessments. A ligature management programme with target completion dates and risks in communal areas had been documented. We could see there were planned works to the garden area outside the boiler room door to remove identified ligature points and we were reassured that the estates team were taking action to remove this risk. Ligature cutting scissors were available with the emergency equipment.
- At the time of the inspection, the bedroom areas were split into two separate corridors for men and women, with two male bedrooms and eight female bedrooms. This met the Department Of Health guidance on eliminating mixed sex accommodation.We were told the split of male and female bedrooms could be changed dependent on the client group gender mix. The signage could be quickly changed so it was clear which gender were living in each of the corridors. Most bedrooms had their own shower and toilet facilities and two of the bedrooms had access to baths from the bedrooms. There was a female lounge available.
- The clinic room was fully equipped and emergency medications were all available and in date. There were good supplies of emergency equipment, oxygen and defibrillators. Resuscitation equipment was in good working order, readily available and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Stocks of emergency medicines were kept in line with trust policy.
- The Deacon Unit did not have a seclusion facility.Staff told us that the positive behavioural management plans and interpersonal relationships with the patients were effective and that a seclusion facility was not required. The service had a calming suite which had its own operational policy to ensure it was managed safely and in accordance with best practice.This area was adapted specifically to suit the needs of the client group and had bespoke calming mood lighting and suitable soft furniture to enable patients to have a space they could use to relax and de-stimulate safely. The staff team from The Deacon Unit had been heavily involved in the development of this area and in the design and manufacture of some of the furnishings so it could be specifically tailored to the nature of some of the clients that might use the service.
- The calming room was also fitted with a touch screen video window which was used to enable patients to interactively play calming games and watch relaxing videos and music. The service had started a quality improvement plan to enable this video window to support patients to access video conferencing with their families but this required additional IT support from the trust.
- The ward environment was cleaned to a high standard. Housekeeping staff were on duty on the wards throughout the inspection. When the housekeeping staff were not available the ward staff maintained additional cleaning duties and these were recorded and up to date. This meant the wards were well maintained, as were the furniture, fixtures and fittings. The corridors were clear and clutter free.
- The equipment used by and for the patients was well maintained, had been assessed, and was within date.

Good

Are services safe?

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- The ward served food that was freshly made every day from the ward kitchen on the unit using local produce. The food was checked and recorded at every meal to ensure it was served at a safe temperature. Food items and cutlery were appropriately stored in a lockable area in the kitchen. The food on the ward was all in date and correctly labelled. Fridges in the kitchen were regularly checked to make sure food was kept at a safe temperature and this was also recorded.
- Staff carried out daily environmental risk assessments and ward audits. For example, there were regular audits of infection control and prevention to ensure that patients and staff were protected against the risks of infection.
- There were notices, that were clearly displayed, that showed hand washing techniques. Information about infection control was displayed on communal notice boards in an easy-read format. Staff and patients had access to personal protective equipment such as gloves and aprons.
- There were appropriate processes in place for the management of clinical waste and staff were able to discuss these with us. We saw that staff disposed of sharp objects such as used needles and syringes appropriately in yellow bins in the clinical room and these were labelled correctly and not over-filled.
- The service had an infrared safety alarm system. All staff carried personal alarm fobs which when activated alerted other staff that assistance was needed and in what location. There were also call bells in patients' bedrooms for them to be able to alert staff should they need assistance. We saw there was a system for checking the alarms in the nursing office and it was the individual staff member's responsibility to check the alarm was working during the course of their shift. This was recorded on a daily basis.

Safe staffing

- The Deacon Unit had enhanced the trust algorithm for identifying the number of staff required to safely manage the patient group.This took into account gender mix and the additional observation levels of the patient group.The unit worked cohesively with the Intensive Support Service (ISS) to ensure that if additional staff were required they were able to cross cover and if the service was running on lower levels of patients the surplus staff were employed to support the ISS team to maintain people in the community.This was an effective way of managing the workforce and maintain safe staffing numbers.

  The trust provided data as of 3 January 2018 for the total number of substantive staff working on the Deacon Unit. Staff numbers were:

- one full time consultant psychiatrist
- one full time band 7 service lead
- two full time band 6 nurses
- three full time band 5 nurses
- 10 full time band 3 support workers.

The psychology/Positive Behavioural Support Lead and other therapy staff worked into The Deacon Unit daily depending on the number of inpatients at any one time. This equated to 50% of their time.

As of the 3 January 2018, the service had the following vacancies:

- one band 5 nurse (the service was looking to re-deploy from another service to fill this vacancy)
- two band 3 support workers (both recruited to and in pre-employment checking stage)
- one band 7 occupational therapist (in recruitment process).
- The trust used key performance indicators to monitor permanent staff sickness and absence levels. In the 12 months leading up to the inspection the sickness levels were 8%, the national NHS average was 5%.This higher figure was due to a staff member being on long term sick leave at the time of the inspection.
- Information provided by the trust showed that three staff members had left the Deacon Unit in the 12 months leading up to the inspection. We spoke with the ward manager who told us that this was due to the re-location of the unit when it opened. We found that most staff who worked at the service had worked in the trust's learning disability services for a long time.
- Even though there was not a significant issue with recruitment and retention within this service the trust had identified the ongoing requirement for staff and was addressing this through recruitment campaigns. The

Good

Are services safe?

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trust had implemented a variety of initiatives to ensure vacancy levels were continuously addressed. The service supported student nurses on placement from local universities and developed the health care worker career pathway.

- When the service did not have enough permanent staff to meet the needs of the ward, bank staff were brought in to help cover the shifts required. Figures provided by the trust showed 697 out of 699 shifts were filled by bank or agency staff in the last six months. The majority of the temporary cover was provided by the service's own substantive staff team working overtime through NHS Professionals. When bank staff were used they were familiar with the ward and patients.
- We looked at staffing rotas for the three weeks prior to and for the week of the inspection and saw that staffing levels were in line with the correct levels and skill mix determined by the trust as safe. The trust data stated that there were only two occasions in the preceding three months where the unit had run under their prescribed staffing level.
- The ward managers and staff confirmed they were able to increase staffing levels when additional support was required to respond to patients' clinical needs. Staff supported patients to attend appointments and ensure their community access and occupational therapy (OT) sessions in the Oasis centre took place.
- All patients on the ward had a named nurse. Patients had regular one–to-one time with their named nurse. This was confirmed by the entries in the patients' care records on the trust's electronic patient record system called System One. Patients we spoke with knew who their named nurse was and told us they saw them regularly.
- Escorted community access and unit activities were never cancelled due to staff shortages. Patients told us there were few occasions when leave or activities were delayed but staff communicated this well. Occupational therapy based activity plans, care and treatment were tailored to the patients' individual needs and were delivered by staff from a wide range of professions.
- Medical staff told us that there were adequate doctors available over a 24 hour period, seven days each week who were available to respond quickly on the unit in an emergency. The trust wide on-call system comprised of one consultant, one junior doctor, one manager and a band seven nurse. There were clear processes in place for staff to follow should medical cover be required.
- Staff were required to complete statutory and mandatory training courses. The trust had 21 statutory and mandatory training courses for all staff. Overall training compliance for all staff was at 89% in statutory training and 88% in mandatory training.

Assessing and managing risk to patients and staff

- Information provided by the trust showed that in the 12 months leading up to the inspection there were no incidents of seclusion or long-term segregation.
- We reviewed information sent to us by the trust relating to the management of violence and aggression. For the period 1 June 2017 to 30 November 2017 there were 21 incidents involving restraint and 10 incidents where rapid tranquilisation had been used. Rapid tranquilisation is the use of medication, usually intramuscular if oral medication is not possible or appropriate, and urgent sedation with medication is required. The trust had policies in place for rapid tranquilisation and managing violence and aggression, which were in line with National Institute for Health and Care Excellence guidance.
- The aim of the service and staff was to focus on the use of positive behavioural support and preventative approaches including de-escalation with minimal use of all restrictive interventions. We reviewed records and found that staff used de-escalation or positive behaviour support proactively.
- Staff applied effective proactive strategies to de-escalate or prevent patients' challenging behaviour and applied reactive strategies when needed as per patients' positive behavioural support plans (PBS). The Deacon centre had an identified PBS lead who was also the clinical psychologist for the unit. A proactive strategy describes what to do on a day-to-day basis to help reduce the likelihood of someone resorting to challenging behaviour in the first place, therefore improving their quality of life.

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- In the five care records reviewed, comprehensive functional assessments had been completed in which ward staff carried out behavioural recording and then used this information to develop PBS plans with the patient.
- The PBS plans were well structured and clearly identified the patients' needs and identified triggers to behaviour that challenges. There were management strategies to enable staff to support patients to maintain positive behaviour. Reactive strategies were also clearly identified and gave step-by-step advice to minimise the likelihood that challenging behaviour would escalate. The patients had an understanding of their PBS plans and thought they helped them.
- Staff had been trained in the use of MAYBO physical restraint but understood that this should only be used as a last resort. MAYBO is a British Institute of Learning Disability accredited technique in physical management technique.Information provided by the trust showed that 83% of all eligible staff had completed training in physical management and 83% in positive behavioural support.
- We reviewed five patients' care records and found risk assessments and risk management plans were fully completed and detailed. Staff carried out risk assessments with patients on admission and regularly throughout their care and treatment. Risk management plans were developed collaboratively between the patient, their family or carer, and the multidisciplinary team, with input from multi-agency teams when needed. This meant that risk was assessed and regularly reviewed and care plans were put in place with the patient to minimise the risk happening again.
- The risk assessment also covered issues relating to physical health care for patients. This was important because the patients had a range of physical health care issues. The Modified Early Warning Score (MEWS) system for physical health care was being used effectively, with the patients receiving regular observations, and appropriate actions were taken as a result of this work.
- There were restrictions in place but these were mostly clinically appropriate for the service's environment. Restrictions included access to the outside garden space and access to the unit kitchen and laundry. However, the service was mindful of the Mental Health Act Code of Practice in relation to blanket restrictions. Restrictions were reviewed, on an individual basis, for patients who had been assessed not to need that level of support, without compromising safety or security.In addition, all staff were aware of reducing restrictive practices whenever possible.
- The trust had a policy on the management of patient observations and the ward followed this. There was a planned system for ensuring that all patients were allocated individual staff members to observe them on a shift-by-shift rotation.
- The trust had a search policy in place. Staff we spoke with were aware of the procedures for the use of personal and room searches. Staff carried out routine searches when patients were first admitted to the unit to ensure that any items that were considered not safe to enter the unit were identified on admission and then could be risk assessed if it was suitable for the patient to access, for example razors.
- Staff handover meetings and multidisciplinary review meetings included a detailed discussion of individual risks for patients.
- Clear notices were in place for patients and visitors explaining the rationale for restricting items such as cigarette lighters and sharps from the unit.These were in the visitors' room and main reception and presented in an easy-read format. There was an information pack available for patients when they were first admitted onto the unit and this clearly detailed which items were restricted.
- All staff undertook adult and child safeguarding training as part of their mandatory training. All staff had undertaken this training. All staff we spoke with were clear about their safeguarding responsibilities and knew how to identify and make a safeguarding referral within office hours and during the evening and weekend. Managers were able to identify their local safeguarding leads and knew how to seek support if they needed it.
- We reviewed five sets of patient medication records. We observed good medication management at the unit. Safe but flexible dispensing was provided so there were no institutionalised practices such as patients queuing for their medication. There was a system in place to monitor reported medication and administration errors. This was supported by regular pharmacy audits which

Good

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By safe, we mean that people are protected from abuse* and avoidable harm

meant that incidents were recorded and analysed, with actions set, so that staff could minimise the risk of reoccurrence. Medication administration errors were dealt with appropriately through discussion with the clinical team at the weekly ward review meeting.

- Each patient had a specific care plan kept with the medication card in relation to each of their PRN medications (when required medications).For example if a patient had been prescribed lorazepam for agitation, there was a specific care plan for how, when and why to use it personalised to that patient's presentation. This meant that staff were using PRN medication more consistently and only after a specific set of alternative interventions had been exhausted.
- Medicines were stored securely and were only accessible to authorised staff. There were robust systems in place for ensuring controlled drugs were managed correctly. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. Medicines requiring refrigeration were stored appropriately and staff monitored temperatures daily in line with national guidance which meant the medicines remained fit for use.

Track record on safety

- There were no serious incidents reported for the unit in the past 12 months. The ward manager was aware of recent incidents that had happened elsewhere in the trust that had affected patient care and had fed this back through the staff team meetings and via email to the staff team. This ensured that all staff were aware of issues that were affecting other inpatient sites.
- There had been no prone (face down) restraints reported by unit in the last six months. There was also low usage of the supine (on the back) position. Between June 2017 and November 2017 there had been 21 reported uses of restraint in total. The most common position that people had been restrained in was standing which was used in 17 of the 21 occasions of restraint.

Reporting incidents and learning from when things go wrong

- We found all staff to be open and transparent, and fully committed to reporting all incidents and near misses. Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system Datix. The ward manager told us they reviewed all incidents and then forwarded them onto the service manager, lead nurse and the quality team. The system ensured that senior managers within the trust were alerted to incidents in a timely manner and could monitor the investigation and response to the incidents.
- Staff told us that shared learning across the trust and service directorates took place about serious incidents and learning was communicated to staff via email, team meetings, staff notices and the trust web page. Staff were encouraged to participate in learning to improve safety as much as possible.
- There were post incident debriefs for staff and patients. Staff we spoke with told us they were debriefed when things went wrong through one-to-one sessions, team meetings and supervision. Staff and patients had access to group and one-to-one support if needed.
- The service listened to staff and patient feedback and made changes to the way the service was delivered. Examples of changes included alterations to patient menus and the inclusion of additional patient activities.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We reviewed five patients' care records. All contained fully completed and comprehensive assessments of patients' individual and clinical needs and preferences.
- All patients had an initial admission meeting where the patient, their family or carer were involved in discussing the issues leading up to admission and to get a comprehensive picture of the patient. Then the unit had a multidisciplinary formulation meeting to agree a shared understanding of the patient's journey of care, clearly identifying what would be required in the lead up to the patient's discharge form the service. The unit used the five P model looking at predisposing factors, precipitating factors, perpetuating factors, protective factors and presenting factors to underpin the clinical practice.
- Staff carried out a range of assessments with patients on admission to the unit and throughout their care and treatment. These included but were not limited to physical health assessment, medication assessment, functional behaviour assessment and analysis.
- All patients had a detailed positive behaviour support plan in place. Positive behaviour support (PBS) looks at the meaning of behaviour for an individual and the context in which the behaviours occur. This understanding assists staff to design more supportive environments and to better support individuals in developing skills that will improve their quality of life. Staff completed antecedent behaviour consequences charts (ABC) to document, monitor and evaluate behaviour. Staff used this to inform behaviour support plans alongside the functional assessments. The unit had a PBS lead who took the lead in maintaining the consistency of the PBS approach but all staff were knowledgeable and confident in discussing how strategies in PBS improved their care of the patient group.
- Care plans were comprehensive, personalised, and holistic and recovery oriented with clear goals set to support patients through their care and treatment pathway. A care pathway is a structured approach to care delivery that clearly describes the journey a person is likely to take when moving through the care system. This ensures that individuals receive the most appropriate care and treatment, with clearly agreed timescales and in the least restrictive environment.
- We saw electronic care plans on System One and the unit used a paper file called "my plan". These were adapted care plans that were easy to read and available in pictorial format. Patients we spoke with told us that they were encouraged and empowered by staff to be to be fully involved in the planning of their care needs. This was evident in the care plans we reviewed which were all person-centred. We saw evidence of patients, relatives and carers being encouraged to be fully involved in the planning of their care needs.
- All patients received a comprehensive physical health check by the doctor on admission. We saw evidence that patients who needed additional physical healthcare were receiving it, with appropriate referral being made when required to the physiotherapy, which was available on the hospital site.
- The care records were stored on an electronic care planning system called System One which could only be accessed by staff. This meant that patients' confidential care planning information was available in an accessible format. All staff were able to access this system, In addition to this the ward kept up–to-date adapted paper copies of the care plans in the "my plan" file which the primary nurses ensured were up to date.

Best practice in treatment and care

- The trust had prescribing guidelines and the psychiatrist referred to these and to National Institute for Health and Care Excellence guidance on prescribing medicines. We reviewed five medicine charts at the service and found doctors had recorded clear rationales for prescribing.
- The Unit was following the NHS England "stopping the overmedication of people with a learning disability" agenda (STOMP LD).This is a 3-year agenda started in 2016, which is designed to make sure people get the right medicine if they need it and that people get all the help they need in other ways as well. Patients had weekly medication reviews and the clinical team was closely monitoring the use of PRN medication. The clinical team also raised awareness within the team of non-drug therapies and practical ways of supporting people whose behaviour was seen as challenging. We

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saw several examples where patients had transferred to the unit from another care setting having been on an antipsychotic medication for a long period. Within approximately six months of admission to the ward, the clinical team had a staged reduction plan in place to support the patients.

- We reviewed five medicine charts and spoke with the consultant psychiatrist, junior doctor and pharmacy team who all confirmed that patients were not on any high dose antipsychotic medication or multiple medications for psychosis. Where possible the clinical team tried to reduce the use of medications alongside other interventions.
- The trust wide pharmacy team provided a clinical service to ensure people were safe from harm from medicines. Nursing and medical staff told us that they had good links with the pharmacy team and in addition to ward visits, and carrying out audits, they were available to provide advice including out of hours. They were also available to speak to patients individually about their medications if required.
- Each patient had a health action plan (HAP) in place. HAP is a personal plan about what the patient needs to do to stay healthy, including a record of past and future medical appointments. Staff referred patients to external healthcare services for treatment when needed such as opticians and dentistry. This was then recorded in the patients HAP. Staff encouraged health promotion including smoking cessation, diet and exercise.
- Each patient had a hospital passport. The passport was designed to help patients with a learning disability or autism to communicate their needs to doctors, nurses and other healthcare professionals. Information about what medicines they were taking, likes, and dislikes and medical history was recorded.
- Risks to physical health were identified and managed effectively by trained staff. The service used a standardised system called Modified Early Warning System (MEWS) to monitor and record the physical health of patients. This system worked by staff allocating a score to a series of physical health measures such as blood pressure and oxygen saturation levels. When a patient's score reached a given level this triggered what action was required from staff. The trust had a physical health monitoring policy. Staff were trained to use the Modified Early Warning Signs tool to observe changes in patient's presentation. The unit had additional training available to the staff team in the implementation of the MEWS tool and five of the staff team had undertaken this training.
- The unit had a psychologist and a psychology assistant allocated to the patient group, sharing their time between the Deacon Unit and the intensive support service. Patients had access to a wide range of evidenced based psychological therapies as recommended by the National Institute for Care and Excellence (NICE) as either part of their care and treatment on a one to one or group basis these included mindfulness sessions and dialectical behavioural therapy (DBT)
- Staff were actively involved in clinical audit on the unit. This included medication monitoring audits, security audits, deep cleaning audits and infection control audits.

Skilled staff to deliver care

- The unit had a full multidisciplinary team available, which worked across the Deacon Unit and the Intensive Support Service (ISS) this included psychiatry, nursing and support workers, psychology, speech and language therapy and occupational therapy input. The ISS service worked alongside the Deacon Unit to provide 24 hours a day 7 days a week care to people with a learning disability who may be experiencing difficulty in the community. It helped to streamline admissions to the Deacon Unit and maintain consistency when patients were admitted and also when they were discharged.This dovetailed team working helped to provide a more consistent approach to this group of patients, with the overall aim to avoid the need for an inpatient admission whenever possible.
- Trust wide staff were also integrated into the team, such as pharmacists and the Mental Health Act team who provided support and advice. In addition, there were domestic staff and administration support based at the service.
- Staff told us they received clinical and managerial supervision every month and an annual appraisal. Staff told us they participated in regular reflective practice

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sessions where they were able to reflect on their practice and incidents that had occurred on the unit. For example, de-briefing meetings took place following an incident on the unit.

- Information provided by the trust showed that staff at the unit were receiving regular supervision. Staff we spoke with all confirmed they received supervision and were happy with the level of support they received. They felt well supported in their team.
- The trust's compliance rate for the number of permanent staff who had received an appraisal in the 12 months leading up to the inspection was 86%.
- The development of staff skills, competence and knowledge was recognised as being integral to ensuring the delivery of high quality care. The psychology department provided additional training such as positive behavioural support training and autism awareness training. Staff also felt well supported with additional training including the opportunity for support workers to complete NVQ and nursing apprenticeships.
- There were regular team meetings and staff told us they felt well supported by their local management structure and colleagues. The ward manager and the service manager were highly visible and available on the ward and staff morale was extremely high.

Multi-disciplinary and inter-agency team work

- The unit had a weekly multidisciplinary team meeting (MDT) called the clinical review meeting. A MDT is composed of members of health and social care professionals. The MDT collaborates to make treatment recommendations that facilitate quality patient care. Patients we spoke with confirmed a number of different professions supported them.
- We observed a clinical review meeting and saw that each member of the team contributed to the discussion. The discussion was effective and focused on sharing information, patients' clinical treatment and reviewing each patient's progress. Staff from different disciplines demonstrated a mutual respect and the views of all professionals were well valued. All staff were actively engaged in activities to monitor and improve patient outcomes. The patients attended the meeting and were able to represent their own views to their team. The meetings were comprehensively structured and minutes of the meetings were detailed and covered all aspects of the patients' mental and physical care and treatment.
- We observed a clinical handover meeting on the unit and found this to be highly effective and structured. Staff used the SBAR handover tool (Situation, Background, Assessment, recommendation). The SBAR handover tool is recognised by NHS England and the Royal College of Physicians as an effective tool for the handing over of care between medical teams.
- We found evidence of inter-agency working taking place, with care-coordinators attending meetings as part of patients' admission and discharge planning. Patients confirmed with us their care-coordinators were invited to and attended meetings. We saw evidence of effective working relationships with the local authority social services in respect of safeguarding concerns. We also saw that representatives from the local commissioning team attended the weekly clinical review meeting to maintain a connection with the service.
- The ward manager attended regular Quality Assurance Group (QAG) management meetings to share good practice and consider ways to develop the services. Senior managers attended monthly governance meetings to review the effectiveness of the service and areas for improvement.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Training in the Mental Health Act was mandatory for all staff. As of 3 January 2018, 75% of staff had completed the training.
- At the time of the inspection, there were no detained patients on the unit.
- Information was displayed on the unit noticeboards regarding the independent mental health advocate (IMHA) and how to contact them. This was displayed in an accessible format that was easy to read. It was also clear that a lot of work had been completed by the unit to ensure all sections of the MHA that may be relevant to the patients at the unit had been represented in an easy-read format.This was available on the walls of the unit with Velcro so it could be removed and discussed with the patients as and when required.

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- Staff supported patients to understand their rights in accordance with section 132 of the Mental Health Act when required. This was routinely recorded on the patients electronic care records.
- Staff at the service had access to the trust's Mental Health Act administration team for support and advice when needed. The MHA team oversaw renewals of detention under the MHA, consent to treatment and appeals against detention.

Good practice in applying the Mental Capacity Act

- There was a trust policy on the Mental Capacity Act (MCA) including Deprivation of Liberty Safeguards (DoLS) which staff were aware of and could refer to.
- At the time of the inspection, four patients were supported on a DoLS at the unit.
- Staff received training in the MCA and DoLS and the trust identified this as core training. At the time of our visit, 100% of staff had completed this training.
- The MCA enables people to make their own decisions wherever possible and provides guidance for decision making where people are unable to make decisions themselves. Staff we spoke with demonstrated a good understanding of the MCA. We observed staff seeking informed consent from patients. Staff held best interest meetings when patients lacked capacity to make decisions about certain aspects of their life or care and treatment. Staff clearly documented the outcome of the best interest decision in patients' care records. Capacity issues were also regularly discussed and recorded in the weekly clinical review meeting.
- Four DoLS applications had been made in the 12 months prior to the inspection and at the time of the inspection two patients were waiting for the outcome of these applications, they were covered by the urgent authorisations and the standard authorisations were being regularly tracked by the clinical team.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- We observed positive and caring interactions between the staff and the patients. Staff were courteous and responsive to patients' requests. All staff in the patient areas were actively engaged with the patients, either speaking with them or encouraging them to take part in ward–based or external activities. Staff had successfully and sensitively formed therapeutic relationships with the patients in their care, some of whom were reluctant to interact due to their illness. We noted several occasions where staff members were supporting a difficult situation with a distressed patient using a structured and consistent approach which was effective in reducing the patients distress
- We saw the unit had received a number of compliments from patients, families and external stakeholders praising the care and support provided by staff to patients. Relationships between patients, families and staff were strong, caring and supportive. These relationships were highly valued by patients and staff and promoted by the multidisciplinary team.
- We spoke with four patients and four sets of relatives/ carers. Patients spoke very highly of the staff and the quality of care they received. They said staff were caring and supportive and they felt truly respected, involved and empowered to make decisions as individuals in the therapies and treatments offered to them. Patients were keen to tell us about specific members of staff they felt had provided outstanding care and support. This was also echoed by the family members we spoke with during the inspection who identified that their relatives were safe and well cared for within the unit.
- Carers told us they felt staff knew the patients very well. Carers felt involved in contributing to patients care plans, were invited to attend care programme approach meetings, and were aware of plans and goals for discharge.
- Staff expressed a caring approach when they were talking about the patient group and it was clear there was an understanding of the patients' individual presenting issues and how best to support them on a daily basis. When staff spoke with us about patients, they discussed them in a respectful manner and demonstrated an extremely high level of understanding of their individual needs. Staff appeared interested and engaged in providing high quality care to patients.

The involvement of people in the care that they receive

- All patients received an initial orientation to the unit and had a 'Patient Information Pack' which was displayed in pictorial format and was easy read. Information included details of the multidisciplinary team, activities and mealtimes, physical health, contact with families and friends and information on how to make a complaint. Patients we spoke with confirmed they received the information pack and felt that it was useful and informative.
- The Patient Advice Liaison Service (PALS) complaints team held monthly 'surgeries' at Deacon to pick up any concerns and explore people's experience to understand further the context of the low number of concerns/complaints received for the service.The Deacon team also facilitated a weekly ward feedback session for current inpatients.
- When we discussed care plans with the patients, we found they were all aware of their treatment goals and they had discussed their goals with both their consultant and primary nurse. There was evidence in the care plans that this was documented and plans were orientated wherever possible towards recovery. Some patients told us they did not have a copy of their care plan but this was their choice.
- Patients reported that when they came into the unit the team had discussed their medication and if appropriate how to reduce the medication regimes safely. Their medication was decided upon with them. A clinician sat down with them and discussed why that medication had been prescribed and what the perceived benefits of it were.
- All patients had an independent mental health advocate through "Advocacy In Surrey". We saw details of the service were displayed on all the wards and patients told us they were supported to access an advocate if they wished. This was displayed in an accessible format that was easy to read and in pictorial format. We saw evidence that advocates had supported patients at review meetings when required.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- Staff enabled patients to be active in their care. We observed staff supporting patients to attend their clinical review meeting and plan ahead of time what they wished to discuss. For patients who did not wish to attend, staff discussed any issues they would like raised with the MDT and then fedback to the patient in a one-to-one meeting the outcome of the discussions.
- Weekly community meetings took place. During these meetings, patients were asked if they were happy at the service and changes were made on a "you said, we did" basis.
- Patients attended regular meetings. Patients were encouraged and supported by staff to plan for clinical review meetings by preparing beforehand. Requests such as home leave, recreational activities and shopping purchases could be made for the multidisciplinary team to consider. Staff and patients reviewed previous issues and actions taken and presented this in a "you said we did" format which was displayed on the ward. Patients said they felt listened to by staff during the meeting and took appropriate action.
- Patients were able to give their views on the service at the weekly community meeting and PALS drop-in. Also a patient satisfaction survey was carried out through the trust electronic "Meridian "system during the year. There was only a small sample of two taken but the results were positive.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- Information provided by the trust showed that in the 12 months leading up to the inspection there were no people from outside Surrey with learning disabilities or autism on this ward. Due to current commissioning arrangements, there were seven beds available for Surrey patients and the potential for three other beds, which could be available for patients from out of area. However, at the time of the inspection the management team of the service were still in the process of bedding in the systems to effectively manage the Surrey patients.
- Patients on leave from the unit had their bed allocated to them and this remained available to them throughout their absence from the service. This meant that should the patient need or wish to return from home leave early they could.
- Beds were available on a referral basis. Referrals for admission to The Deacon Unit came from the Intensive Support Service (ISS) and the teams worked collaboratively to ensure patient continuity of care was maintained.
- Clinical staff and members from the senior management team for The Deacon Unit, ISS team, the commissioning teams and the local community teams attended a weekly bed management and referrals meeting, to review all patients within the unit and to consider any potential referrals into the unit.
- As part of the transforming care programme for people with learning disabilities, the service was discharge oriented and committed to achieving a sustained reduction in the number of patients admitted to the wards. We were told that in the 12 months prior to the inspection the ISS team had managed to successfully support over 50 patients in the community meaning that they did not have to be admitted to The Deacon Unit.
- Staff undertook thorough pre-admission assessments which ensured that only patients whose behaviours that challenged or whose mental health issues were to a degree which meant they could not be managed safely or appropriately in the community were admitted to the ward. Pro-active discharge planning took place from the point of admission. The multidisciplinary team were all actively involved in deciding when a patient was ready for discharge.
- We reviewed five care records and found that staff and patients regularly discussed discharge planning during weekly transforming care meetings. Clear care and support plans and an estimated date of discharge were put in place. A range of external professionals including care managers, social workers, community care staff, relatives and carers and commissioning bodies attended pre-discharge meetings. When patients were moved or discharged this happened in a planned way to ensure the patients' wellbeing during the discharge process.
- Patients received regular care and treatment reviews. An NHS England review team carried out these multidisciplinary assessments. They ensured that patients were getting the right care, in the right place that met their needs and they were involved in decisions about their care. Outcomes and recommendations were then made.
- Information provided by the trust showed that in the 12 months prior to the inspection there were four delayed discharges from the unit. We reviewed the reasons for these delays and could see that the service was making continuous attempts to transition the patients out of the service but the delays were not in relation to the care provided by The Deacon Unit.
- The average length of stay for people has reduced from 18 months to 5 months since opening in 2017. There have no re-admissions since the Deacon Unit has been opened

The facilities promote recovery, comfort, dignity and confidentiality

- The unit environment had a full range of rooms and equipment available and was comfortable. This included space for therapeutic activities and treatment and bespoke furniture which was suitable for people with a learning disability and autism.The furniture was smart and in good order but also safe and comfortable.Several of the staff were involved with the design of specific pieces of furniture within the unit to ensure it was suitable for the patient group.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

- The unit was furnished to a good standard, in excellent repair and with high levels of cleanliness.
- The unit had a bespoke "calm room" which was designed as a sensory regulation area which patients could independently access or access with support from staff members.This room was not a restrictive area and there was no internal locking system on the door which meant that patients were able to leave the room should they wish.The room had calming mood lighting which could be controlled by the patient and comfortable bean bags and soft furniture to assist in pro-active self-regulation of behaviour.The room also had its own private adjoining ligature-assessed toilet facility.The room had a multimedia touch screen which could play music and had activities and games available to patients.
- There was no dedicated multi-faith room for the patient group. We were told there had been no need for its use up to this point but this was something the ward manager had already considered how to resolve by using the visitor room when required.
- The unit offered patients' access to a secure outside space with seating available and outside activities available. At the time of the inspection this area was being landscaped with a gradually sloped walking track designed to improve patients' fitness. There were also grassed and patio areas.
- The meals provided by the unit were all cooked on site in the unit's own kitchen. The food was ordered from the local supermarket and the staff and patients were involved in the preparation and cooking, if risk assessments allowed. The kitchen was large and well organised with equipment that could be adapted to suit people who may have a physical disability, this included a bespoke work surface that could be raised and lowered to suit patients who used a wheelchair or who preferred to cook standing up.
- Patients had the ability to personalise their bedrooms and were encouraged to put pictures of their family or things they liked in painted frames on the wall. The overall effect of this was to make the bedroom more homely and familiar. The bedrooms also had televisions built into the wall which could be independently controlled or could be controlled from a central place on the unit.
- Patients were free to access their bedrooms at any time. Bedrooms could also be locked by staff or left open depending on patient's request. Most patients preferred to leave their bedroom doors unlocked so they could access these at any time.Patients told us they were offered a key fob for their rooms but preferred not to have one.
- All patients were able to store their possessions securely in their bedrooms in a locked cabinet. Patients' bedroom doors had a vistamatic window, which allowed staff to carry out observations without the need to open the bedroom door. These vistamatic panels were self-closing so the default position was always closed to maintain the patient's dignity in their rooms.
- Patients on the unit had access to an activities programme. Occupational therapy staff worked with patients to develop a variety of individual sessions that were based on the therapeutic value of the activities. They operated a model which focused on a holistic, person-centred, and recovery-based approach. The activities programme covered evenings and weekends and included sports, cooking, and for some patients, swimming. Patients could also have their own mobile phones. The unit had access to a public phone which was designed into the wall and available at all times.
- Activities sessions were also co-ordinated so patients could carry out activities with their family members' support. For example, one patient enjoyed rowing with their father so this was incorporated into their weekly timetable.
- The unit had a kitchen area and patients were able to have snacks and drinks throughout the day or night. Patients were not able to have free access to hot drinks as the drinks station was temporarily not being used while it was waiting for temperature control valves to be fitted to the boiler unit following a risk assessment of the patient group. This restriction was made on safety grounds and we saw that this was regularly reviewed and plans were in place to get it back in operation.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Meeting the needs of all people who use the service

- The unit was built and designed to support the needs of patients with physical disability when required. Several of the clinical team from the previous service had been involved in the design layout of the service and how it would fit within the parameters of the listed building.
- Information was clearly displayed on communal noticeboards on all the wards in an accessible and easy–to-read format including pictorial. This included information for the Patient Advice and Liaison Service (PALS). Patients we spoke with felt confident that they could make a complaint if they needed to. Staff were aware of the process for managing complaints.
- Dietary needs were well met. The unit staff were aware of the dietary requirements for each patient and at the beginning of each week when the shopping was ordered patients' likes and dislikes and nutritional needs were taken into consideration.
- Staff supported and encouraged patients to keep in contact with relatives and important people in their lives with ward and home leave visits, community access and telephone contact. The calm room had a multimedia touch screen which had the ability to support video conferencing but due to IT issues in relation to confidentiality this could not currently be used in this manner. However, the unit was reviewing this with the trust to consider how to enable it to be used fully.

Listening to and learning from concerns and complaints

- Patients and carers told us they knew how to complain. Patients were given information about how to make a complaint in the 'patient information pack' they received and information was clearly displayed on the ward noticeboards. This included information for the Patient Advice and Liaison Service. Patients and carers we spoke with felt confident that they could raise a complaint but had not needed to do so. Staff were aware of the process for managing complaints.
- In the 12 months leading up to the inspection the service had received no complaints and had received multiple compliments from family members and carers.
- Staff were aware of duty of candour requirements, which emphasise transparency and openness. The duty of candour requires NHS and foundation trusts to notify the relevant person of a suspected or actual reportable patient incident.

Are services well-led?

Outstanding ☆

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- The ward manager and service manager were aware of the trust's vision and values and the trust "quality house" was clearly displayed on the unit. Staff spoke passionately about the trust and clearly felt valued and proud to work for the organisation and specifically the Deacon unit and the Intensive Support Service.All the staff we spoke with felt connected to the objectives and involved in the quality improvement initiatives developed within the unit.
- The ward manager had regular contact with the service manager and director. Staff knew senior managers from the trust and told us that they had visited the unit.

Good governance

- Staff had access to a wide variety range of statutory and mandatory training to support them in their roles. Staff had excellent opportunities to attend specialist training to support them in developing their practice and improve care and treatment outcomes for patients. Data provided by the hospital showed that statutory training was 90% and mandatory training was 88%. This is in line with the trust's expectation of 90% compliance with training.
- Staff received regular supervision in line with trust policy. We reviewed the last 12 months' supervision data and could see that regular supervision was recorded and staff confirmed this to be the case. Staff we spoke with told us they felt well supported by their managers through the formal supervision structure but also felt they could approach the management team for advice whenever they felt it necessary.
- The ward manager had autonomy to run the unit. The nurse in charge on each shift could increase staffing levels if they felt this was warranted due to increased patient need. There was a clear pathway for this through the ward manager and all staff said they were well supported by the ward manager and other senior staff in the event this was required.
- Staffing levels on the unit were appropriate. There was sufficient staff on shift and staff were appropriately skilled and qualified to ensure the safety and wellbeing of the patients were being met.
- The safeguarding, Mental Health Act 1983 and Mental Capacity Act 2005 procedures were clear with identified leads and managed well.
- Incident reporting was managed using an electronic system Incident records were reviewed by senior managers and discussed at senior manager meetings. The incident feedback loop was effective as ward staff told us they were aware of outcomes from incidents that had occurred on the unit, which had been discussed by the clinical team.
- Staff were involved in a wide variety of national and local clinical audit programmes, research and peer review projects which were designed to improve and enhance the quality of service provided to patients.

Leadership, morale and staff engagement

- There were low levels of sickness absence in the unit. Staff expressed how much they enjoyed their work and the therapeutic relationships they built with patients. Staff were positive and optimistic about patients and this was evident in the interactions we observed across the unit.
- At the time of our inspection, there were no grievance procedures, allegations of bullying or harassment reported across the unit.
- We found the unit to be well-led and there was clear leadership at a local level. The ward manager and service manager were visible on the ward during the inspection and it was clear they had an active role in the patients' day–to-day support and were accessible to staff and patients.
- The clinical team were motivated to inspire and support staff to succeed. Staff described strong leadership on the ward and said that they felt respected and valued. The ward manager spoke highly of the staff and felt they provided a good service, with positive outcomes for patients and families.
- Staff knew the whistleblowing process and said they would be able to raise concerns if the need arose, and were encouraged and supported to do so without fear of victimisation.

Are services well-led?

Outstanding ☆

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- There was high staff morale across the clinical team. All the staff we spoke with were enthusiastic and proud about their work and the care they provided for patients on the unit.
- Staff told us they were encouraged and supported to discuss ideas within the team. We saw a number of quality improvement projects that staff were actively engaged in to support their drive for continuous improvement in the quality of care and treatment for patients and their experiences.

Commitment to quality improvement and innovation

- The Deacon Unit participated in the Royal College of Psychiatrists' quality network for learning disability services (QN-LD). Staff visit other learning disability services around the country and benchmark those services against a set of criteria and key performance indicators. The aim is to improve the quality of the service they are visiting but it also enables the service to identify areas that work well and bring those ideas back to The Deacon Unit. The last peer review took place on 16 November 2017. The peer review report found that the service met 99% of the Type 1 standards and 97% of the Type 2 standards.
- The Deacon Unit followed the NHS England "stopping the overmedication of people with a learning disability" agenda (STOMP LD).This is a 3-year agenda started in 2016 which is designed to make sure people get the right medicine if they need it and that people get all the help they need in other ways as well. Patients had weekly medication reviews and the clinical team closely monitored the use of PRN medication. The clinical team raised awareness within the team of non-drug therapies and practical ways of supporting people whose behaviour was seen as challenging.
- The unit was successful in meeting the criteria for AIMS-LD.AIMS –LD is the Royal College of Psychiatrists' quality assurance standard that recognises good practice and high quality care and helps identify and address areas for improvement.
- The unit had successfully introduced quality improvement projects in the implementation of the MEWS to monitor and support physical healthcare needs and the introduction of the SBAR handover process.