Kent and Medway NHS and Social Care Partnership Trust

Wards for people with a learning disability or autism

Inspection report

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Date of inspection visit: 28 March and 4th, 5th and 6th April 2023
Date of publication: 21/07/2023

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Our findings

Wards for people with a learning disability or autism

Requires Improvement ↓↓

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Our rating of this service went down. We rated it as requires improvement because:

Right Support:

Model of Care and setting that maximises people's choice, control and independence

The ward was located on the outskirts of Dartford. It was local to amenities, shopping centres and other activities so that people could access the local community, both escorted and unescorted.

People had independent access to the communal kitchen and laundry (where risk assessed as safe). People had their own en-suite bedrooms on the ward with shared access to communal areas including living spaces and a dining room. People could personalise their rooms and staff had supported them with this.

The ward environment was clean and well maintained. The ward furniture was homely and welcoming and there were spaces on the ward for people to see visitors or spend time alone.

Staff supported people to be independent. Staff focused on people's strengths and promoted what they could do, so people had a fulfilling and meaningful everyday life.

People were supported by staff to pursue their interests and people said they had engaged in activities if they wanted to do.

Staff worked with people to plan for when they experienced periods of distress and staff did everything they could to avoid restraining people.

Staff enabled people to access specialist health and social care support in the community. They supported people to attend dental, optician, and other physical health appointments.

Right Care:

Care is person-centred and promotes people's dignity, privacy and human rights

Most people received kind and compassionate care. Staff protected and respected people's privacy and dignity. People and their relatives said that staff looked after them well and treated them with respect.

Our findings

Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. People told us they felt safe.

People's care, treatment and support plans reflected their range of needs, and this promoted their wellbeing and quality of life.

Right Culture:

The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

Staff knew and understood people well and were responsive, supporting their aspirations to live a quality life of their choosing. People and their relatives knew what their goals were and where they planned to move to.

Staff placed people's wishes, needs, and rights at the heart of everything they did.

People and those important to them, including advocates, were involved in planning their care. Relatives told us they were invited to meetings and were kept updated by the family engagement and liaison lead.

Staff ensured risks of a closed culture were minimised so that people received support based on transparency, respect, and inclusivity. Staff were welcoming and the ward environment was calm and inviting.

People told us that leaders on the wards were visible and approachable. Staff used clinical and quality audits to evaluate the quality of care. People and governance processes helped the service to keep people safe, protect their human rights and provide good care, support and treatment.

However:

The service had not always ensured that staff had sufficient training to support and meet the needs of people who used the service. Most staff that we spoke with told us that they had generic mental health backgrounds with little to no previous experience working with people with learning disabilities and autistic people. Although there were various training opportunities including an induction, which was also available to existing staff, and autism training delivered on the ward, these were not mandatory, and some staff were not able to identify the specific needs of people using the service. Since inspection we were told that some support staff had years of experience working with people with a learning disability and autistic people, both within the Trust and at other services. The service also had five, out of nine nurses who were registered learning disability nurses. The impact of this meant that we could not be assured that the provider was ensuring that all staff had the right skills and understanding to provide the right care to people with a learning disability and autistic people. At the time of inspection, three members of staff were not up to date with the mandatory training course Immediate Life Support.

The ward had a blanket restriction on garden access, and as such there was limited access to outdoor space. The garden doors were the boundary of the locked ward and as such, people using the service accessed this under the supervision of staff or, if unescorted, in pre-booked hourly slots.

Some people told us that staff sometimes had an attitude and were rude when they spoke with them. One person gave an example of a staff member who told them they were "busy" when they asked them for something. During our Short

Our findings

Observational Framework (SOFi) at lunch time we initially observed two staff sitting on a line of chairs on the wall opposite to the dining tables where people were sat eating lunch and this did not create a warm and inclusive atmosphere. During the earlier tour, a staff member told us that this was where staff sat to observe people during mealtimes.

There was a lot of information on notice boards around the ward which was not always in easy read. Some people told us that they found the information on noticeboards quite overwhelming, and one person told us that they do not take anything in from these notice boards. We observed one person asking staff for help finding information on a notice board as they said they could not read it.

People told us that due to staff toilets and a linen cupboard being on the same corridor as their bedrooms, the noise from the opening and closing of these doors often woke them at night. People told us that they had raised this but that nothing had been done. We saw that this had been raised in a recent MDT meeting when discussing the experience of people using the service.

People prescribed paraffin-based skin products did not have a fire risk assessment in place.

The fridge on the ward had been broken since January and medicines were being stored in another ward on the same site. The provider had a new fridge ready to be installed, however at the time of the inspection, the fridge had still not been made accessible to staff to use and store medicines which required refrigeration.

We did not always see the clear involvement of people recorded in nursing care plans, such as physical health care plans, as these were not always completed from the person's perspective.

Background to inspection

On 28 March 2023 we carried out this unannounced comprehensive inspection at Brookfield centre and announced activity on 4, 5 and 6 April 2023 at both Brookfield centre and Tarentfort centre. This was in response to several sexual safeguarding notifications received from the local authority and the Trust. We decided to inspect to ensure that the services were safely caring for people and managing any risk appropriately. The service was also due a current inspection due to the time since the last inspection.

Kent and Medway NHS and Social Care Partnership Trust provide care and treatment for people with a learning disability and autistic people at Brookfield Centre, Dartford. Brookfield centre was a 13 bedded locked rehabilitation inpatient service for males aged 18 and over with a learning disability, offending behaviour and mental health or other complex needs. This ward was often a step down service for people previously at Tarentfort Centre, which was a low secure environment for people with a diagnosis of learning disability and autistic people. There were 12 people using the service at the time of our inspection and all 12 people were detained under the Mental Health Act.

Brookfield Centre is registered to provide the following regulated activities;

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury

Our findings

Brookfield centre sits under the Forensic and Specialist service directorate of the Trust and had the same overseeing senior leadership team as the Tarentfort Centre which was also inspected at the same time. Tarentfort Centre was previously considered under the core service of Wards for Learning Disability and Autism, though due to commissioning changes since the last inspection, this centre is reported under Forensic inpatient and secure wards core service.

We previously inspected this core service in January 2017 and we rated the wards as Outstanding, in all five domains and overall. At this inspection, we told the Trust that it should take action to ensure that staff receive regular ongoing training on the Mental Health Act. We found that this was now in place and staff we spoke with were able to tell us about the Act and its principles.

Mental Health Act Reviewers also visited the site to carry out a review within the same timeframe and completed a separate report of their visit.

What people who use the service say

People told us that they felt safe on the wards and that they could always find nursing staff when they needed them. People told us that they were also able to speak to psychologists, social workers, and doctors when they needed to.

People told us that most staff were nice, kind and treated them with respect. One person told us that "staff were nice people, treated us nicely and cared about us". Although, four people told us that staff sometimes had an attitude and were rude when they spoke with them. One person gave an example of a staff member who told them they were "busy" when they asked them for something. Three out of the four people who told us this said that they experienced this from bank staff, not permanent staff.

People told us that they had activities such as cinema, football, golf, pool, and basketball. Although some people said that staff shortages sometimes affected their leave and activities. They did tell us that when this happened staff spoke with them to let them know and usually rearranged this.

People said that they could phone their relatives to keep in contact and that the service facilitated visits. People told us that staff kept their relatives up to date on their care.

People told us that they felt comfortable on the ward, had their own access to their bedrooms and a kitchen and laundry room (if risk assessed as safe) and liked that they could use their e-cigarettes in their bedrooms. People told us that the ward was always clean and that their bedrooms were cleaned daily. Although, one person told us that they had to be signed out by staff to use the fenced garden and that they were limited on how long they could spend there.

People told us that they were involved with their care planning and that if they wanted, they had copies. People were also included in their ward rounds and told us that their discharge plans were discussed during this.

People had contact with advocates or knew how to contact them if they needed. People told us that they were read their rights under the Mental Health Act regularly. People knew how to make a complaint and told us that the ward manager was approachable and sorted problems out for them. People told us that they had a community meeting every week where they could raise concerns and issues.

Some people did raise issues with noise and told us that due to staff toilets and a linen cupboard being on the same corridor as their bedrooms, the noise from the opening and closing of these doors often woke them at night. People told us that they had raised this but that nothing had been done.

Our findings

Some people told us that they found the information on noticeboards quite overwhelming, and one person told us that they do not take anything in from these notice boards.

There was mixed feedback about the food, most told us it was average, and some told us it was good. People told us that they got to choose the food they wanted from the menu and could also use the kitchen to make their own food (if risk assessed as safe).

What carers and relatives of people who use the service say:

Relatives told us that they were satisfied with the care their relatives received. They felt that the service had made good progress with each of their family members and gave positive praise for their involvement and communication with staff from the service.

Is the service safe?

Requires Improvement 

Our rating of this service went down. We rated it as requires improvement because:

Safe and clean care environments

People were cared for in wards that were safe, clean well equipped, well furnished, well maintained and fit for purpose. People told us that the ward was always clean. We saw that all ward areas were clean and well furnished. People told us that their rooms were cleaned by housekeeping daily and there was also a rota on the ward which encouraged people using the service to be involved in tidying up the communal ward spaces such as the kitchen and dining room. Although, one of the gardens, which people and staff told us was used in summer months, had some disused items such as empty boxes and broken furniture discarded.

People were cared for in wards where staff had completed risk assessments of the environment and removed or reduced any identified risks. The service had a ligature risk assessment which was reviewed annually. This appropriately identified all potential risks, and these were reduced through identified controls. The ligature risks within the environment were also on the ward based and wider directorate risk registers, the latter of which was monitored centrally. Environment risk assessments, including fire exits, were carried out daily and a staff member was allocated as the responsible health and safety lead on each shift.

People had easy access to nurse call systems and staff had easy access to alarms. People using the service had access to nurse call systems within their bedrooms and tests were run on these regularly. Staff members were given personal safety alarms upon entering the ward and these were checked daily to ensure they worked. The ward had CCTV in place in communal areas and screens in the nursing office and security room. There was good visibility from the nursing and managers office across the ward and there were convex mirrors in place to address any blind spots.

The service admitted people safely to the service. The service had a guided process in place for admissions to the service. This included an assessment led by a consultant psychiatrist and registered nurse and a specific admissions criteria to ensure that the person being admitted was able to be safely cared for and their needs for treatment

appropriately met. A weekly referrals meeting was also in place and attended by members of the multidisciplinary (MDT) team. This was to review the appropriateness of the referral and decide on an outcome based treatment plan. We observed this meeting during our inspection and saw that it was well attended by all members of the MDT and that relevant risks surrounding the admission were discussed.

The service's infection prevention and control policy was up to date. The policy had been reviewed in February 2023. We saw good hygiene practices on the ward and there was also information on infection prevention and control around the ward. People told us that during COVID-19 they had experienced an outbreak on the ward and staff contained and managed this. Staff completed monthly hand hygiene audits.

Staff checked, maintained, and cleaned equipment. We saw that all daily and weekly checks had been done of all emergency equipment and medical devices including a crash bag, glucometer calibration and the medication fridge. Cleaning records were in place and up to date and the clinic rooms were neat and tidy. Staff told us that these allocated tasks were carried out during night shifts and at weekends.

Safe staffing

The service had enough nursing and medical staff, who knew the people and received basic training to keep people safe from avoidable harm. At the time of the inspection, the ward had five support workers and one nurse on duty. The service sent us rotas which identified that staffing levels were arranged to be two nurses and four healthcare support workers on early shifts, an additional nurse and healthcare support worker covering mid shifts, two nurses and four support workers for evening shifts and one nurse and two healthcare support workers for night shifts. There was an average of 10 unfilled shifts for registered nurses and 21 unfilled shifts for healthcare support workers per month based on the last three months. This equated to approximately 6% of all registered nursing shifts and 7% of all healthcare support worker shifts on the ward for that month. Managers told us that they regularly filled shifts with bank staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and health care assistants for each shift. The ward manager could adjust staffing levels according to people's needs. For example, if someone had home leave booked which required 2:1 staffing, this would be appropriately planned for. Managers told us that the priority was always that the ward had safe numbers of staff. In the last year the service had three registered staff and four unregistered staff leave.

The service only had two current vacancies for full time healthcare support worker positions. There was a current recruitment strategy in place shared with the vacancies on Tarentfort Centre to fill these positions. The service did not use any agency staff. Managers made sure all bank staff had a full ward induction and understood people's needs before starting their shift. Staff recruitment and induction training processes promoted safety.

Some people told us that sometimes their escorted leave or activities were cancelled at short notice due to short staffing. They told us that when this happened staff spoke with them to let them know and rearranged this. We saw in documentation of a Care, Education and Treatment Review (C(E)TR) action plan dated from December 2022 that home leave arrangements had being affected at short notice. Managers confirmed that this had happened occasionally and told us that when it did this was due to unexpected issues on the ward on the day of leave and that they worked hard to ensure this was rescheduled as soon as possible. Managers also told us, as was similarly documented within the action plan mentioned above, that there was flexibility to facilitate and increase leave, although this was dependent upon the staffing available for escorted leave and planning for timings and transport.

Our findings

The service had enough daytime and night-time medical cover, and a doctor was available to go to the ward quickly in an emergency. The service had a responsible clinician who was a psychologist, and medical and prescribing support was received from approved clinicians at the neighbouring site. The service had a duty doctor rota and an on call forensic psychiatrist outside of working hours. They also had good links with the local acute hospital for any physical health emergencies.

The numbers and skills of some staff matched the needs of people using the service. The service had a total of nine nurses, of which five were registered learning disability nurses with backgrounds and experience working with people with learning disabilities. Although, most staff that we spoke with told us that they had generic mental health backgrounds with little to no previous experience working with people with learning disabilities and autistic people. Managers told us that although they tried to ensure at least one registered learning disability nurse was always on shift, there would be times where this was not possible.

Most staff had completed and kept up to date with their mandatory training. The ward was currently 93% compliant with the Trust's essential training although there were a few courses which fell below the target of 90% including immediate life support (66.6%) and medical gas safety for nurses (66.6%). Managers explained that this was linked to staff sickness and staff changes and we did see reminders given to staff within team meeting minutes. Immediate life support training ensures staff are up to date and equipped with the necessary skills and knowledge to manage a deteriorating patient and to treat cardiac arrest in absence of emergency services. Therefore, at the time of inspection, we were not assured that all staff on a shift would be up to date with their training in immediate life support this could lead to a significant risk if this was required by people using the service. Since inspection, the Trust has advised that this was three members of nursing staff, two of which we have been told have since completed this training.

The training programme was comprehensive and included various training opportunities including safeguarding adults (up to level three), positive communication, dual diagnosis, moving and handling, patient safety and personal safety, equality and diversity, physical interventions, patient safety for staff, mental health act, mental capacity act, conflict management, food hygiene, basic and immediate life support, boundaries training and freedom to speak up.

Assessing and managing risk to patients and staff

People's care records helped them get the support they needed as staff kept high quality clinical and care records, although it was not always easy for staff to access these. Staff kept accurate, complete, legible and up-to-date records, and stored them securely. All staff could access people's records which were all on a password protected electronic recording system and staff accessed information governance training yearly as a mandatory training item. However, although all staff had access to the assessments and knew where on the system to find them, these were not always quick and easy to find within the stored location due to the way they were uploaded onto the system. Senior nurses and leaders within the directorate were aware of how this impacted the efficiency of locating information and told us that they were working to develop the system.

The service assessed, monitored, and managed safety well. People told us that they felt safe on the wards and we observed a calm environment whilst onsite. People's risk assessments were thorough, individualised, and detailed and were reviewed regularly. Staff used different individual risk assessment tools including the Short-Term Assessment of Risk and Treatability (START) and Historical Clinical and Risk Management 20 (HCR-20). All people had individual risk assessments to enable access to the communal kitchen, laundry room, laptops, mobile phones, and Section 17 leave. Section 17 leave is for certain people who are detained under the Mental Health Act (MHA) to be granted leave of absence from the hospital for a specified period or subject to specific conditions.

Our findings

Each person's care and support plan included ways to avoid or minimise the need for restricting their freedom. Staff knew about any risks to each person, and prevented or reduced risks. People's comprehensive risk assessments clearly identified risks and their supporting care plans and positive behaviour support (PBS) snapshots provided staff with the information on how to prevent and minimise risks. People were involved in managing risks to themselves and in taking decisions about how to keep safe. People told us that they were involved in their risk assessments and support plans. Within their positive behaviour support plans (PBS), people worked with psychology staff to identify strategies they could use when they felt distressed. This may involve strategies that they could use on their own or things that staff could help them with, such as removing certain items from their rooms or going for a walk around the grounds.

Staff could recognise signs when people experienced emotional distress and knew how to support them to minimise the need to restrict their freedom to keep them safe. Staff monitored the presentation and engagement of people during the night and day through observations and reported on this at handover meetings. 92% of staff had also completed the See, Think, Act training which focused on staff having the knowledge and understanding of the person and the environment to identify raising signals of a potential incident. Staff identified and responded to any changes in risks to people or posed by them and staff gave examples of working with the individual to understand the triggers to their behaviour so that escalation of these could be prevented in the future. Staff described positive risk taking whilst still supporting the rehabilitative aims of the person's treatment. For example, staff gave a recent example of a person who had lost access to leave from the Ministry of Justice due to increased risk, however staff worked with the Ministry of Justice to allow therapeutic leave so that this individual was still able to access treatment and fresh air.

The service helped keep people safe through formal and informal sharing of information about risks. Staff shared key information to keep people safe when handing over their care to others. Any changes to clinical risk and strategies were discussed collaboratively at handovers between shifts and in the daily multidisciplinary meetings. The service also held person focused meetings where they were able to discuss as a multidisciplinary team any challenges, learning and strategies to improve the care of people.

People's freedom was restricted only where they were a risk to themselves or others, as a last resort and for the shortest time possible. In the last three months, there had been no recorded restraints or seclusion incidents on the ward. All staff we spoke with told us that restraint was rarely used on the ward and de-escalation techniques were always used first. Seclusion was not used at Brookfield Centre and at the time of inspection there were no people in long term segregation. We found that Rapid Tranquilisation (intramuscular injections for the management of severe agitation and aggression) had not been used on the ward for any of the people using the service at time of the inspection and staff informed us this was only used as a last resort.

The service had a reducing restrictive practice meeting which the ward manager attended monthly. Local governance and wider governance processes ensured that any incidents of restraint and seclusion were appropriately monitored and reviewed. The Trust had a Restrictive Practice policy in place which was up to date and which staff were following. Security searches were carried out on people following unescorted leave. Staff also told us that they carried out random searches on people's bedrooms as per their policy and additionally if there were concerns.

The ward had a blanket restriction on garden access, and as such, there was limited access to outdoor space. The recorded rationale for this was that the perimeter of the ward stopped at the garden door and we were told that this was a Trust wide blanket restriction due to a previous absconsion at another service, as well as wider risk management of the people using the service and the neighbouring communities. People using the service accessed the garden under the supervision of staff and were able to request access up until 10pm, or within daylight hours in the winter. The Trust told us that during the Summer months the garden was open far more frequently. Some people with appropriate leave

authorisation had unescorted garden leave which required them to pre-book hourly slots. One person we spoke with who had unescorted leave told us that that they had to be signed out by staff and that they were limited on how long they could spend there. The Trust have explained that people using the service with unescorted leave are encouraged to access the hospital grounds, local community and beyond as part of their wider rehabilitation prior to discharge.

At the time of the inspection, eight of the twelve people using the service did not have unescorted garden leave. For some this was due to risk and being newly admitted, for five this was due to Ministry of Justice (MoJ) restrictions which were out of the Trust's control. Still, this was a blanket protocol that affected all people using the service and the Trust have said that a review of the protocol was currently taking place, and that the centre were exploring the least restrictive option for people so that the garden can be used safely.

People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so. The service had a lead social worker who met with the local authority safeguarding team monthly to review any incidents and any potential safeguarding issues. There had been no recent safeguarding incidents raised on the ward. People and their relatives told us that they felt safe on the wards.

Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had trained 88% of staff in safeguarding adults and children at level three and 100% of staff at level two. In addition, the lead social worker offered monthly safeguarding training to support staff and additional safeguarding awareness inputs for staff away days.

People had safeguarding information in a form they could use, and they knew how and when to raise a safeguarding concern. People were aware of safeguarding and knew who to speak to if they had any concerns. We saw safeguarding information around the ward.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. All staff we spoke with gave examples of safeguarding concerns and told us that although they had not had to make any safeguarding referrals, they knew how to if they needed to. Any staff member was able to make a referral.

Staff followed clear procedures to keep children visiting the ward safe. Staff worked with the person if a child were to visit and assessed if there were likely to be any safety issues. These visits usually took place at another building off the main ward site.

Medicines management

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles. Intramuscular rapid tranquilisation (RT) was rarely used on the ward and there was a process which was followed to make sure it was only used as a last resort. Whilst RT had not been used on the ward staff were able to provide us with assurances that they understood how to use it safely and the process that had to be followed if RT was administered. Use of 'when required' (PRN) medicines to manage agitation and aggression on the wards was consistent with the acuity of the people there when recorded. Whenever possible, de-escalation would avoid using a PRN medicine with comprehensive behavioural support plans in place that were made with the help of the people and the psychology team. Staff consistently recorded why a PRN medicine was needed and if it had been successful in people's progress notes. Use of PRN medicines were regularly reviewed, and prescribing stopped when no longer necessary.

Our findings

The pharmacy department provided expert clinical advice to prescribers and staff. They supported the safe and effective use of medicines including reviewing and reducing prescribed medicines in line with the STOMP principles. They also ensured additional monitoring and safety considerations were being followed prior to a medicine being administered.

People received support from staff to make their own decisions about medicines wherever possible. Pharmacy staff attended ward rounds where peoples care including prescribed medicines were discussed with a multidisciplinary team. We saw evidence of regular reviews of people's prescribed medicines and an active drive to remove unnecessary restrictive medicines.

Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines. Staff worked with people to balance clinical effect and side effects to find a treatment that worked best for individual people. Records of these conversations were kept in peoples records and were discussed with the MDT when they met.

People could take their medicines in private when appropriate and safe. People on the ward were able to store their medication in locked safes within their bedrooms and administer this on their own when they reached the 'stage three' medication management programme, however there were no people on the ward doing that at the time of the inspection. Staff supported people with their medication in stages one and two.

Staff followed current national practice/guidance to check people had the correct medicines. Staff followed national practice to check that people had the correct medicines when they moved into a new place or they moved between services. Pharmacy technicians or pharmacists would attend the ward and complete a full medicines reconciliation (the process of accurately listing a person's medicines) within 24 hours of admission to the ward during normal working hours. The Trust monitored compliance with this target.

Staff reviewed the effects of each people's medication on their physical health according to NICE guidance. Staff ensured each persons' physical health was monitored regularly. There was a physical health lead nurse who supported staff with managing and monitoring people's physical health needs whilst on the wards. Each person had access to an independent GP service which would also support people's medical needs on the wards. Any medicines or treatment regimens that required additional monitoring had these carried out within the required timeframe.

People received their medicines from staff who prescribed, administered, recorded and stored their medicines safely. Staff used an electronic system to prescribe and record the administration of medicines. Medicines were all stored in locked cabinets. Access to this was limited to authorised staff only. Although people prescribed paraffin-based skin products did not have a fire risk assessment in place.

Temperatures for the room, cabinets and medicine fridges were taken daily by staff. Although, the fridge on the ward had been broken since January and medicines were being stored in another ward on the same site. The provider had a new fridge ready to be installed, however at the time of the inspection, the fridge had still not been made accessible to staff to use and store medicines which required fridge temperatures. Where medical gases were stored these were secured and in date.

Track record on safety

The service managed incidents affecting people's safety well. Staff recognised incidents and reported them appropriately and managers investigated incidents and shared lessons learned. The Trust had a serious incident policy in place to ensure the consistent approach to the recording and management of incidents that met this threshold. The service was in the process of transferring over to a new incident system and at the time of inspection some records from

Our findings

the previous system had still not been transferred over. Both systems were reviewed and there had only been two incidents within the previous three months. One of these incidents involved a person damaging property in their bedroom and immediate action was documented on the system which identified how staff responded to keep the person safe. The second incident involved a person going absent without official leave (AWOL) whilst on community leave due to frustrations around financial issues. These had been categorised as low level incidents and no serious incidents had been recorded.

People received safe care because staff learned from safety alerts and incidents. Staff spoke about the recent incidents with us and identified the actions they took to understand the person's thinking and feelings which helped them to identify and understand the trigger to the behaviour for future action. The service shared learning from incidents and complaints across the Forensic and Specialist directorate via a quality newsletter sent to staff monthly. We saw in the most recent examples that there had been recommended learning taken from people who had gone AWOL. This information is also repeated in monthly patient safety presentations which were shared with the directorate senior management teams and local clinical governance meetings.

When things went wrong, staff apologised and gave people honest information and suitable support. Managers and staff told us that they always held reflective debriefs with staff and the person or people involved. The service also used restorative practice to help manage conflict and resolve incidents on the ward. Restorative practice brings those harmed by conflict and those responsible for the harm into communication, enabling everyone affected by a particular incident to play a part in repairing the harm and finding a positive way forward. Leaders told us that they had been accredited for their work in using this within the healthcare setting.

The service recorded any use of restrictions on people's freedom, and managers reviewed use of restrictions to look for ways to reduce them. Managers held a blanket restrictions assessment and log which was reviewed regularly by the ward manager and responsible clinician.

Is the service effective?

Requires Improvement ↓↓

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff completed a comprehensive assessment of each person's physical and mental health either on admission or soon after. People had care and support plans that were personalised, holistic, strengths-based and reflected their needs and aspirations, including physical and mental health needs. The service used a "My Shared Pathway" model of care which focused on the plan being centered around the person and their family and carers. It included areas such as my mental health recovery, stopping my problem behaviours, my life skills, my relationships, and my discharge plans.

People, those important to them and staff reviewed plans regularly together. People told us that they had weekly one-to-one sessions with their named nurse and that they were involved in their care plan reviews, and that their relatives, (with their consent), were also involved. Staff told us that care plans were reviewed weekly and updated at least every three months. People told us that they were given copies of their care plans if they wanted them and were always

offered them. Although, we did not always see the clear recording of people's involvement in nursing care plans, such as physical health care plans, as these were not always completed from the person's perspective. Psychology care plans, such as my problem behaviours and drug and alcohol recovery, were much better at recording the clear involvement of the person.

Care plans reflected a good understanding of people's needs, including relevant assessments of people's communication support and sensory needs. All people had care plans related to their individual needs and included up to date assessments. Every person's record contained a clear one-page profile with essential information so that new or temporary staff could see quickly how best to support them. Each person had a positive behaviour support 'snapshot' which identified the most important information about their care and treatment. Although all staff told us that they knew where to find the information on the system, we did find issues with being able to find assessments quickly and easily due to the area where they were uploaded on the system. Leaders were aware of this being an issue and were working with technology teams to try and resolve this.

There were clear pathways to future goals and aspirations, including skills teaching in people's support plans. People learned everyday living skills, understood the importance of personal care and developed new interests by following individualised learning programmes with staff who knew them well. Each person had personalised therapeutic plans that linked in with outcome goals and measures which staff told us enabled them to see how the activities and skills they undertook, linked in with the achievement of goals which were reviewed in ward rounds.

Best practice in treatment and care

Staff supported people with their physical health and encouraged them to live healthier lives. This included access to psychological therapies, support for self-care and the development of everyday living skills. People had both group and individual sessions available to them that assisted in developing independent living skills including money skills, transport practice, cooking groups, laundry, and personal care. People were actively engaged in the development of groups that they felt they needed and co-facilitated sessions with staff. Psychological therapies were also available for people's mental health needs. These included cognitive behavioural therapy, trauma therapy, psychotherapy of Eye Movement Desensitisation and Reprocessing (EMDR), Dialectical behaviour talking therapy (DBT) therapies and family work. Psychology staff also facilitated offence focused work with people where needed and gave an example of this. These could all be adapted to meet individual needs.

People also had access to several leisure activities, morning, afternoon, and evening seven days a week. These were based both on the ward and at the therapy centre building opposite. These included pool, music therapy, cooking and baking, pet care, movies, gardening, gym and sports. In addition, people told us that they also got to go off the ward to play golf, football, fishing and to go to the cinema which they enjoyed. We observed activities taking place on the ward including staff playing pool with people and a group arts and craft activity taking place on the ward for National Autism Awareness week. There were also resources for self-directed entertainment including CD's, books, board games and laptops for internet access (where risk assessed).

Some people using the service had positive behavioural support (PBS) plans which were developed by Psychology staff. Although not all people using the service had PBS plans, those that did, had comprehensive plans. These were kept in folders within the office. Every person's record contained a clear one-page profile with essential information so that new or temporary staff could see quickly how best to support them. This 'snapshot' identified the most important information about a person's care and treatment including their key triggers and behaviours to be aware of. One person for example had a specific plan around what to do when they heard voices and how to help manage this to keep the person safe.

Our findings

Staff made sure people had access to physical health care, including specialists as required. We saw evidence of people being referred to dentists, opticians, and orthopaedics. The service had a speciality doctor who supported the clinical team with physical health concerns. They also had a visiting GP who attended once a week for referrals. There was also a physical health nurse who worked across the services who held regular drop ins for people to discuss any physical health concerns. We saw evidence of a separate physical health care diary on the ward which ensured that physical health observations and planned medical appointments were organised and allocated to staff to support.

Staff helped people live healthier lives by supporting them to take part in programmes or giving advice. The activities available for people included health promotion and healthy walking groups. People were also supported with smoking cessation treatments/therapies, if people wanted them.

Staff took part in clinical audits, benchmarking, and initiatives. Managers used results from audits to make improvements. The service carried out a varied range of clinical audits and developed one-page summaries from these audits which were shared with staff for learning and placed on the ward for the awareness of people using the service and their relatives. These summaries included the aims of the audit, best practice, lessons learnt and recommendations. An example of a recent clinical audit at Brookfield centre was a review of therapeutic activity and the recording of people's engagement with this. Recommendations had been made to ensure that when an activity is offered to a person that it was recorded whether they chose to partake or not. These audits were repeated so that they could see whether improvements had been made. Brookfield centre also benchmarked against other providers through the Accreditation of Inpatient Mental Health Services (AIMS) scheme for Rehabilitation services. This accreditation by the Royal College of Psychiatrists facilitated peer review visits to identify areas of achievement and improvement, as well as a culture of openness and enquiry. They received this accreditation in April 2022 and will be accredited until May 2024. In addition, managers told us that they were working towards accreditation with the National Autistic Society to quality assure themselves of the support and care they provided to autistic people. They have people from the service involved in the working group for this.

The service told us about several initiatives and innovative practice. This included people using the services co-delivering some autism training to staff at Brookfield centre, ongoing restorative practice work, and an anti-racism working group with various projects including development of the Active Allyship Group and programme. The latter, which was agreed by people using the service, involved specific care plans and a report to the police for individuals who displayed racist behaviour. This was to address the racial abuse received by staff working with people on the wards. One person told us that they were happy with this agreement as they did not like the racial abuse displayed by some people on the ward. In addition, staff were involved in various research topics such as sex offender treatment for men with a learning disability, the use of Eye Movement Desensitisation and Reprocessing (EDMR) on people with a learning disability, staff experiences of racism at work and recently published collective research on working with people with autism in the Criminal Justice System.

Skilled staff to deliver care

People using the service received good care as managers supported staff through regular supervision, appraisal and recognition of good practice. This created a positive work culture. Staff told us that they received regular supervision (at least six weekly). The data provided to us showed that 95% of staff had received supervision. We also saw evidence of this being discussed within team meeting minutes. Staff had yearly appraisals and the data they provided showed that they were 100% up to date.

However, some staff were not able to provide examples of specific needs of people owing to their diagnoses. There has always been an expectation that services caring specifically for people with a learning disability and autistic people ensure that staff have the right skills and knowledge to provide safe care to these people. Some staff were not able to

provide examples of specific needs of people owing to their diagnoses and some staff we spoke with also explained that they had very little experience working with people with learning disabilities and autistic people. One permanent staff member told us that they had done their own reading at home to help improve their understanding. Since inspection we were told that some support staff had years of experience working with people with a learning disability and autistic people, both within the Trust and at other services.

The essential training list received at the time of inspection did not include any specific training inputs on working with people with a learning disability and autistic people. The service provided evidence of specialist induction training for the directorate which showed three days of skill training and inputs and included sessions on communication, working with people with learning disabilities and working with autistic people which were run twice a year. We saw evidence that this programme was advertised for all existing staff to attend, although this was not mandatory and the Trust have told us that 41 staff members across the low secure services have attended this over the last two years. The service also provided a proposed five day timetable due to start later this year with the same agenda, as well additional inputs including closed cultures. A closed culture is a poor culture in a health or care service that increases the risk of harm. The Trust have since told us that it was hoped that this training will become mandatory training for staff.

In July 2022, the Health and Care Act 2022 set out a mandatory training requirement for learning disability and autism for the health and social care workforce. The government recommended the Oliver McGowan mandatory training on Learning Disabilities and Autism which became available in November 2022 and provided two tiers of training dependent on what was appropriate for staff's roles. During inspection some staff told us that they had received correspondence around mandatory training for people with a learning disability and autistic people although they were not clear on what this was. Due to the nature of this service, the mandatory training was being delivered in two parts. The first part, available and mandatory for all staff from the beginning of April 2023, was an e-learning package. The second part, involving face to face training, was to be rolled out in Autumn once they confirmed a provider for this training. The Trust have told us that these courses need to be completed within six months of one another and that they were working to procure this face-to-face training provision by October 2023. Currently, 81.48% of staff at Brookfield have completed the mandatory e-learning.

The impact of some staff not having adequate knowledge and training meant that we could not be assured that the provider was ensuring that all staff had the right skills and understanding to provide the right care to people with a learning disability and autistic people.

If staff had to restrict people's freedom teams held debriefing meetings and reflected on their practice to consider improvements in care. These involved the person when they were ready. They also held person focused meetings where, as a multidisciplinary team, they discussed any strategies that would improve care for people.

Staff were knowledgeable about and committed to using techniques which reduced the restriction of people's freedom. All staff we spoke with were knowledgeable about how they supported people to reduce restrictions on their day to day lives. They all told us how they worked with the person to deescalate situations and that restraint was rarely used. 80% of staff were trained in physical interventions and 100% of staff were trained in positive communication.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. People told us that social workers, occupational therapists, psychology staff and speech and language therapists all visited the ward and that they had good access to them when needed. Social workers held weekly drop in clinics for people.

Our findings

The ward team had effective working relationships with wider staff from health and social care services that would provide aftercare following people's discharge and engaged with them early on in people's admission to plan discharge. The service worked closely with community-based care coordinators, social workers, commissioners, and specialist teams including the Learning Disability Forensic Outreach Liaison Service (LDFOLS) team and Multiagency Public Protection Arrangements (MAPPA)/ police Violent and Sexual Offender Register (VISOR) teams in organising the discharge pathway for people. There was a fortnightly system wide discharge planning meeting system-wide fortnightly discharge planning meeting called 'Homes not Hospitals' where peoples discharge plans were discussed regularly.

People had health hospital passports that enabled health and social care services to support them in the way they needed. A *hospital passport* tells the hospital about a person's healthcare, learning disability, how they like to communicate and how to make things easier for them.

Multidisciplinary team professionals were involved in or made aware of support plans to improve care. Multidisciplinary team members worked collaboratively on people's care plans. The service also held person focused meetings where they were able to discuss as a multidisciplinary team any strategies to better improve the way they could work with people.

Staff shared clear information about people and any changes in their care, including during handover meetings. Staff shared key information to keep people safe when handing over their care to others. Any changes to clinical risk and strategies were discussed collaboratively at handovers between shifts and in the daily multidisciplinary meetings.

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

Staff understood their roles and responsibilities and explained to each person their rights under the Mental Health Act in a way that they could understand, repeated it as necessary and recorded it clearly in the people's notes each time. People told us that staff read their rights to them monthly and we saw this documented within care records. Staff we spoke with were able to identify the principles of the act and their roles and responsibilities with this. Although all people on the ward were detained at the time of the inspection, we saw information on the entrance and exit to the ward to advise people who were there informally of their rights also.

People had easy access independent mental health advocacy, and people who lacked capacity to make decisions for themselves were automatically referred to the service. The service had an independent mental health advocate (IMHA) who attended the service on a weekly basis. People told us that they had regular contact with an IMHA and others who did not, knew how to contact them if they needed to. Although, there was little information on the wards about the IMHA as the noticeboard containing this information had been damaged some months previously and was yet to be replaced. The Trust has since told us that the noticeboard was on order at the time of the inspection.

Staff respected the rights of people with capacity to refuse their medicines and ensured that people with capacity had the option to consent to receiving medicines. People had a valid legal authorisation for medical treatment that was regularly reviewed by the clinician in charge of the treatment. There was a record of consent to treatment on or soon after admission which was reviewed routinely. Consent to treatment documents were in place in the clinic rooms and were being followed. Staff could check these against what they were administering. All people told us that they felt involved in making decisions about their medicines where this was appropriate. Staff worked with people to find a treatment that worked best for them. Records of these conversations were kept in people's records and were discussed with the MDT when they met.

Our findings

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or the Ministry of Justice or both. There was a standardised system for the administration of section 17 leave. Leave was appropriately recorded including specified conditions and escorting requirements. Leave was based on an up-to-date risk assessment. People understood the leave that was authorised for them.

Staff stored copies of people's detention papers and associated records correctly, and staff could access them when needed.

Good practice in applying the Mental Capacity Act

Staff followed best practice on assessing mental capacity, supporting decision-making and best interest decision-making. Staff empowered people to make their own decisions about their care and support, and obtained people's consent in an inclusive way.

For people that the service assessed as lacking mental capacity for certain decisions, staff clearly recorded assessments and any decisions made on their behalf were in their best interests. For people lacking capacity to make decisions about their medicines, staff followed best practice. We saw one person using the service who was assessed to lack capacity around their medication and this was appropriately identified in the care plan.

When staff assessed people as not having capacity to make decisions for themselves, they made decisions on people's behalf in their best interest and considering their wishes, feelings, culture and history. If consent was given, people told us that their relatives were also involved in the decisions around their care.

Managers and staff made sure the service applied the Mental Capacity Act correctly by completing audits and discussing the findings. The service provided evidence of a clinical audit they had completed into mental capacity assessments for people who refused physical health monitoring or interventions. The purpose of this audit was to measure compliance and ensure that all people had equal access to physical health monitoring and interventions in line with their needs. They found that 67% of people had capacity assessments completed, discussed, and recorded and identified learning and recommendations.

Is the service caring?

Good ↓

Our rating of caring went down. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff respected people's privacy and dignity. People told us that staff treated them with dignity and respected their privacy. They told us that staff always knocked on their door before entering their bedrooms and we observed staff doing this whilst we carried out a tour of the ward. Bedroom doors had viewing panels that could be operated from the inside. People were able to identify their preferences as to how they wished to be observed on their bedroom doors which they told us they were happy with.

Most staff treated people with compassion and kindness. Most people told us that staff treated them kindly. Staff showed warmth and respect when interacting with people. We observed warm and genuine interactions between people and staff. Some staff clearly knew people well and had a positive therapeutic relationship with them. Staff spoke passionately about the people they worked with.

Our findings

Although, four people told us that some staff sometimes had an attitude and were rude when they spoke with them. One person gave an example of a staff member who told them they were "busy" when they asked them for something. Three out of the four people who told us this said that they experienced this from bank staff, not permanent staff. We fed this back at the time of the inspection and the Trust told us that concerns raised by people using the service was fed back to the organisation responsible for bank staff as part of monthly ongoing contract reviews.

Although, during our Short Observational Framework (SOFi) at lunch time we initially observed two staff sitting on a line of chairs on the wall opposite to the dining tables where people were sat eating lunch and this did not create a warm and inclusive atmosphere. During the earlier tour, a staff member told us that this was where staff sat to observe people during mealtimes. However, as the observation went on, a few staff brought their lunch and sat with the people using the service and interacted with them throughout the meal. This was much more relaxed, and people appeared to enjoy staff's presence and conversation.

People had the opportunity to try new experiences, develop new skills and gain independence. Staff explored what people wanted to achieve and supported them to try out new activities. People told us that they were able to suggest new activities and things to do. Staff told us that they focussed on maximising people's independence and encouraged them to balance leisure activities with activities that increased life skills, for example there were rotas for people to cook for themselves weekly, to do their own laundry and to help tidy and clean up. People also had access to ward laptops which enabled them to access online banking.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards people. All staff told us that they were aware of how to raise concerns if they had any about how people were being cared for.

Involvement in care

Staff involved people in care planning and risk assessment and sought their feedback on the quality of care provided. People told us that they were involved with their care planning and risk assessments, and that if they wanted, they were given copies of these. People were also able to feedback in their ward rounds, Care Programme Approach (CPA) and Care, Education and Treatment Review (C(E)TR) meetings. Although, we did not always see the clear recording of people's involvement in nursing care plans, such as physical health care plans, as these were not always completed from the person's perspective. Psychology care plans, such as my problem behaviours and drug and alcohol recovery, were much better at identifying clear involvement of the person.

People were listened to, given time, and supported by staff to express their views using their preferred method of communication. People told us that they had regular one to one's with named nurses and were also able to speak to the staff they wanted to. Staff we spoke with identified the importance of listening to the person. There were also community meetings weekly which gave people the opportunity to feedback any views or concerns. People told us that they felt able to make complaints and knew how to. They also completed regular surveys to feedback on their care. There were "you said, we did" boards present on the ward although the information shown on these appeared quite out of date (with most actions from 2021/2022).

Staff introduced people to the ward and the services as part of their admission. People were provided welcome packs prior to admission and staff went through these with people once they arrived to ensure their understanding. People received a ward orientation soon after admission and there was also a "buddy system" where existing people using the service helped to show newly admitted people around the environment.

Our findings

Staff made sure people understood their care and treatment (and found ways to communicate with people who had communication needs). People were provided letters which set out their care and treatment pathways and intended discharge plans prior to admission. These could be given in accessible formats depending on the person's needs.

Staff informed and involved families and carers appropriately. The service had a family engagement and liaison lead who maintained regular contact with family members. All carers were invited to attend ward rounds (including virtually), CPAs, and discharge planning meetings if requested and consented by the person using the service. The family engagement and liaison lead also organised carers forums and updated families through regular newsletters. Staff helped families to give feedback on the service as carers were given feedback surveys to complete.

Relatives told us that they were satisfied with the care their loved ones received. They felt that the service had made good progress with each of their family members and gave positive praise for their involvement and communication with staff from the service.

Is the service responsive?

Good ↓

Our rating of responsive went down. We rated it as good because:

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. The service worked closely with community-based care coordinators, social workers, commissioners, and specialist teams including the Learning Disability Forensic Outreach Liaison Service (LDFOLS) team and Multiagency Public Protection Arrangements (MAPPA)/ police Violent and Sex Offender Register (VISOR) teams in organising the discharge pathway for people. There was a fortnightly system wide discharge planning meeting system-wide fortnightly discharge planning meeting called 'Homes not Hospitals' where peoples discharge was discussed regularly, and leaders raised any system delays with commissioners. People told us that their discharge plans were regularly discussed at their ward rounds and CPA meetings.

Managers regularly reviewed people's length of stay to ensure they did not stay longer than needed. Managers told us that they reviewed people's length of stay along with local authorities and commissioners to look at intended and expected discharge dates and to ensure that they were working towards these. Any delays in discharges were often due to finding the appropriate supported living placement for people to move on to or legal frameworks needing to be put in place to help with the management of an individual's risk, such as civil orders. Staff told us that most people only stayed on the ward for around two years, with the data provided to us showing an average length of stay as 25 months.

If a person was not from the local area staff supported them, in line with their wishes, to have regular contact with family, friends or an advocate. At the time of the inspection, all people using the service were referred from Kent based commissioners. Staff supported people to have contact with their family by supporting them or their relative to travel and supporting them with video or phone calls. An advocate visited the hospital weekly.

When people went on leave there was always a bed available when they returned. People's leave was planned, and their bed was not filled until they had been formally discharged from the hospital.

Our findings

Staff carefully planned people's discharge and worked with care managers and coordinators to make sure this went well. Staff told us that they worked with people to help them visit placements, and even stay overnight, before being discharged to them. Staff also had good relationships with care coordinators to plan their onwards care.

Staff supported people when they were transferred between services. As Brookfield centre was often a step-down service for people who previously had been at the Tarentfort centre, staff supported people with this transition. We spoke with one person who had recently transferred over who told us that it had been good and that he felt supported with this move.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported people's treatment, privacy and dignity. Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. There was just one room which did not have their own en-suite access but instead had access to a shared bathroom. Staff told us that no other people used the bathroom other than the person whose bedroom joined to this bathroom. People were able to personalise their bedrooms with their own personal items including televisions, games consoles and pictures. Managers told us that they were looking to redecorate the ward and that people would be able to choose the colours that their bedrooms were painted. There were lockers on the ward where people could keep personal belongings safe.

The service's design, layout and furnishings supported people and their individual needs. The ward was all on one ground level with wide corridors and doorways. Managers told us that adaptions could be made if required. People could change the lighting in the room to support any sensitivities as they had access to night lighting and lamps (where risk assessed as safe). However, some people did raise issues with noise and told us that due to staff toilets and linen cupboard being on the same corridor as their bedrooms, the noise from the opening and closing of these doors often woke them at night. People told us that they had raised this but that nothing had been done. We saw that this had been raised in a recent MDT meetings when discussing the experience of people using the service, although there was no recorded action for staff relating to this issue.

The service had quiet areas and a room where people could meet visitors in private. The ward had a multi-use room where people could meet with visitors in private. There was also a quiet room with soft furnishings and a small lounge where staff told us people could go to relax.

People could make phone calls in private. People had a ward phone which they could use at anytime to make calls and some people had use of their personal mobile phones. They were able to make calls in their own room or somewhere private on the ward.

The service had two large, fenced gardens, one accessed from the communal and small lounge and another from the bedroom corridor. However, there was a blanket policy that restricted access to the gardens. One person told us that they had to be signed out by staff to use the garden and that they were limited on how long they could spend there. The Trust told us that the garden doors were the boundary of the locked ward and as such, people using the service accessed this under the supervision of staff or, if unescorted, in pre-booked hourly slots. This was due to wider risk management of the people using the service and the neighbouring communities.

There were mixed reviews over the quality of the food with some people telling us that it was average and others telling us that it was good. During the SOFi we observed all people eating their lunch and one was overheard to say it was "nice". People told us that they got to choose what they wanted each day and were also able to visit the onsite canteen for a meal each week. People could make hot drinks and snacks at any time. We saw that there was fresh fruit and hot/

cold drinks available in the communal areas for people. People also had unrestricted access (if risk assessed as safe) to the communal kitchen with fridge and freezer facilities to store and make their own snacks. There were some restrictions for individual people on takeaways and unhealthy snacks due to concerns for health and budget and this was agreed with people using the service.

Patients' engagement with the wider community

Staff supported people with family relationships and community activities outside the service, such as work, and education. People told us that they regularly went into the community for activities and leave. Two people using the service also went to the local college for education. Staff also supported people to volunteer at the onsite canteen which one person on the ward was doing. They told us that this gave them a sense of worth and helped to prepare them for future work opportunities.

All people said that the service facilitated these visits. There were visiting hours for the ward although staff told us that they were flexible with this and were able to accommodate visits outside of these hours if planned. There was a visitors room on the ward which was comfortable and spacious, and we saw visits taking place during our inspection. People also told us that they could phone their relatives to keep in contact. There was access to a ward phone that people could use at any time and some people (where risk assessed) had access to their own mobile phones. People could also use the ward laptops for video calling.

Staff gave people person-centred support with self-care and everyday living skills. Staff supported individuals in the way they wanted to be supported and helped them to increase their independence skills. People looked clean and well dressed in individual styles that were appropriate to their age and the activities they were doing.

Staff enabled flexibility and helped people to have freedom of choice and control over what they did. The activity timetable included a range of options for leisure and living skills activities which people were able to choose from.

Staff ensured adjustments were made so that people could take part in activities. Staff told us that certain activities were able to be delivered in a group or a 1:1 setting if people preferred. Staff spoke enthusiastically about supporting people to try out new activities and promoting opportunities to do this.

Staff encouraged people to develop and maintain relationships both in the service and the wider community. All people told us that they got on well with others on the ward and we saw them engaging well with each other during our inspection.

Meeting the needs of all people who use the service

The service met the needs of all people – including those with a protected characteristic. Staff helped people with communication, advocacy and cultural and spiritual support. People's care plans detailed how they wanted to be supported to meet all their needs including communication, cultural and spiritual needs. There was a multi-faith room on the ward which contained articles of faith such as a Quran and the bible. The service also had access to a visiting chaplain. Where appropriate, people were supported to visit external places of worship.

Staff used person-centred planning tools and approaches to discuss and plan with people how to reach their goals and aspirations. Staff discussed ways of ensuring targets for people were meaningful. They spent time with people understanding how they could be achieved. Each person had personalised therapeutic plans that linked in with outcome goals and measures which staff told us enabled them to see how the activities and skills they undertook, linked in with the achievement of goals which were reviewed in ward rounds.

Our findings

People were supported with their sexual/ religious/ ethnic/ gender identity without feeling discriminated against. The service met the needs of all people using the service, including those with needs related to their protected characteristics. People were referred to by their preferred name and the information around preferences was in people's communication profiles. The service also had numerous recourses to meet spiritual, cultural and gender needs.

People had individual communication plans/ passports that detailed effective and preferred methods of communication, including the approach to use for different situations. These were developed following assessment by the speech and language therapist and were individual to people. Managers told us how they had reworked the communication passport, autism passport and sensory passport into one document. This was a way of drawing together complex information (including the person's own views, as much as possible) and putting this into a clear, and accessible format. Staff told us that they were also looking to do this for hospital passports too.

There was lots of information leaflets and posters available throughout the communal areas and corridors of the ward with information on treatment, local services and their rights. The activity timetable included a couple of images and there was also information on boards to inform people about staffing. There was no board for advocacy or details of how to complain to the CQC as this had been damaged and awaiting replacement. The Trust has since told us that the noticeboard was on order at the time of the inspection. Still, all people we spoke with had access to an advocate or knew how to get access and knew how to complain.

However, the information on the notice boards was not always in easy read format or accessible for people. People we spoke with told us that they found this quite overwhelming, and one person told us that they do not take anything in from these notice boards. During our SOFi we also observed one person asking staff to help him find the information he wanted on the board as he could not read it. One of the clinical audits carried out by the service also identified that the format of the therapeutic programme given to people was not simple or easy to read and had recommendations to address this.

Although, staff told us that they offered choices tailored to individual people using a communication method appropriate to that person, including providing information in different formats depending on an individual's needs. Staff told us that not all people wanted information in easy read, and some preferred to be supported to read information instead and that this was discussed with people at every ward round. We were provided examples of easy read and adapted versions of documents that showed how pictorial and talking mats style approaches were available and used if required. These approaches use pictures as a communication tool to support people with communication difficulties to share their thoughts and/ or think about a topic.

Managers made sure staff and people could get help from interpreters or signers when needed. Staff had access to an interpreting service if needed.

Listening to and learning from concerns and complaints

People and those important to them could raise concerns and complaints easily, and staff supported them to do so. Although there was no information clearly displayed on the ward on how to make a complaint, people told us that they felt comfortable and knew how to make complaints. Most people told us that they would approach the ward manager in the first instance and were confident that their issues would be resolved.

Our findings

Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them. People had weekly community meetings where they were able to give feedback on any concerns or issues. People told us that they felt comfortable raising issues and would go to the ward manager in the first instance, with confidence that action would be taken. People also told us that they attended ward rounds, CPA and C(E)TR meetings where they also had the opportunity to feedback. People also completed regular experience surveys to feedback on their care.

Staff protected people who raised concerns or complaints from discrimination and harassment. Staff knew how to acknowledge complaints, and people received feedback from managers after the investigation into their complaint.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. Managers shared feedback from complaints with staff, and learning was used to improve the service. The service shared learning from incidents and complaints across the Forensic and Specialist directorate via a quality newsletter sent to staff monthly. We saw evidence in a recent newsletter that there had been learning around telephone etiquette of staff following a complaint within the wider directorate. In the last four months, Brookfield centre had one complaint relating to staff attitude and communication style which was still being investigated. Managers told us that any learning actions identified from complaints was taken forward via team meetings / discussions.

The service also received and shared compliments that had been received within the service. We saw two recent compliments that had been given to the service by family members. One thanked staff for everything they had done for their loved one and said they would miss everyone who helped with their loved ones care and treatment. Another thanked staff for the kindness they showed allowing their loved one to attend a relative's funeral. We saw that these were also shared in the quality newsletter across the directorate.

Is the service well-led?

Good

Our rating of well-led went down. We rated it as good because:

Leadership

Leaders had the skills, knowledge and experience to perform their roles and had a clear understanding of people's needs and oversight of the services they managed. Management and staff put people's needs and wishes at the heart of everything they did. The service had an experienced senior leadership team. The ward manager and responsible clinician in charge of the ward demonstrated that they understood and considered the needs of the people using the service and their relatives.

Leaders worked hard to instil a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish. All staff we spoke with said they felt valued and supported in their role. Staff understood their role in enabling people to move on successfully back into the community and spoke passionately about working with the people using the service.

Managers were visible in the service, approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say. Both people using the service, and staff spoke highly of the visibility and approachability of the ward manager and responsible clinician. They told us that they always listened to them. We observed the visibility of leaders on the ward and their familiarity with people using the service and staff.

Our findings

Leaders and senior staff were alert to the culture in the service and as part of this spent time with staff/ people and family discussing behaviours and values. Managers and people on the ward told us about the racial abuse received by staff working with people on the wards. Staff told us how their experiences of this had a significant impact on them and some people using the service told us how uncomfortable this was for them to witness. The service were involved in an anti-racism working group to address the racism experienced by staff within the service and this included a report to the police for individuals who displayed racist behaviour.

Vision and strategy

Staff knew and understood the provider's vision and values and how to apply them in the work of their team. The service applied the core values of the Trust which included respect, openness, accountability, excellence, innovation and working together. These were displayed on the ward so that people using the service and their relatives knew what behaviours and values they could expect to see from staff. During inspection, we also observed staff behaved in the way that showed they respected the providers values and all staff we spoke with said these reflected their day to day job role.

The provider had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible. We saw that staff wanted to do the best possible job they could in delivering care. Staff we spoke to told us that people were a priority and at the forefront of everything they did. Most people told us that they felt that staff cared for them and their wellbeing.

Managers set a culture that valued reflection, learning and improvement. They were receptive to challenge and welcomed fresh perspectives. All staff we spoke with told us the ward was approachable and welcomed feedback from staff on how to improve things. The service held "meet the manager" sessions and had a workforce "you said, we did" process. Any items from these were fed into the clinical governance agenda for wider discussion.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. The service recognised staff achievement in the quality newsletters. All staff told us they knew how to raise concerns and would not hesitate to if needed. Two members of staff told us that they had experienced issues with other staff and explained how the ward manager worked with them to resolve the concerns. Staff knew about the Freedom to Speak Up and whistleblowing policies. One person told us that they had used the Freedom to Speak Up guardians and were complimentary of the advice and support they received from this service. Information was displayed about the speak up process on the ward and staff received essential training on this.

The service had not always ensured that staff had sufficient training to support and meet the needs of people who used the service. The training opportunities were not mandatory, and some staff were not able to identify the specific needs of people using the service. The service have introduced part of the government recommended mandatory training for staff working with people with a learning disability and autism and outlined their plans to have the complete offer of this training by October 2023. The Trust have also told us that they are looking to make their in-house programme of training mandatory which includes relevant inputs for staff working with the needs of this service.

Governance

Governance processes were effective and helped to hold staff to account, kept people safe, protected their rights and provided good quality care and support. Staff discussed risks relating to individuals, incidents, and staffing levels for the day in the daily morning meeting. Any issues were escalated to multidisciplinary meetings held daily.

Our findings

There were weekly service line governance meetings and monthly directorate quality and clinical governance meetings. We saw that the agenda included discussions around: serious incidents including lessons learnt, safeguarding, risk registers, reducing restrictive practice, quality improvement projects, care records, audits, complaints and compliments, and feedback from people using the service, carers and advocates. The weekly service line governance meetings discussed specific areas of the wider clinical governance agenda each week and this fed into the monthly care group meeting and the wider Trust wide governance meetings. Information from all of these governance levels was also able to be filtered down to ward level team meetings. This meant that relevant information was being shared across the right channels.

Staff used recognised audit and improvement tools to good effect, which resulted in people achieving good outcomes. Staff did clinical audits, benchmarking and quality improvement work to understand and improve the quality and effectiveness of care. The service had audit systems in place to assess and monitor the standards of care and action was taken where shortfalls were identified. The service had a governance lead who monitored and reviewed data relating to the service to identify any concerns or themes. The service carried out regular audits including those of the environment, care, and medicines, as well as thematic clinical audits on different areas of the service including therapeutic programmes for example. The purpose, outcomes and recommendations of these were put into clear one-page documents, which were disseminated to staff for learning and placed onto the wards.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff had access to people's individual risk assessments and care plans and showed they had read these. The service had an overall risk register which staff also had access to. This covered high risk areas of the ward and described mitigations to manage the risks. We also saw evidence of a clear referral and admission process, with inclusion and exclusion criteria which supported leaders to manage inappropriate referrals and ensure that they only admitted people they could support and care for safely.

Staff were committed to reviewing people's care and support continually to ensure it remained appropriate as people's needs and wishes changed. People told us, and we saw, that care plans were regularly reviewed. The multidisciplinary team reviewed each person's risk at the daily morning meeting and at ward rounds.

Staff were able to explain their role in respect of individual people without having to refer to documentation. They gave good quality support consistently. Throughout our inspection we observed that staff supported people well.

Staff acted in line with best practice, policies and procedures. They understood the importance of quality assurance in maintaining good standards. There was an appropriate clinical governance structure in place to ensure information and risk was escalated and managed in a timely manner. Leaders confirmed that organisational policies and procedures from the wider Trust were applied to the operational running of the ward and that updates to these were shared with staff. The policies and procedures that we received from the service were clear and regularly reviewed.

Information management

Staff collected and analysed data about outcomes and performance and engaged in local and national quality improvement activities. Clinical governance meetings showed that managers had analysed data and bench marked these across the wider directorate.The staff routinely completed Health of the Nation Outcome Scales (HONOS), which is a recognised rating scale to assess and record outcomes for people. We also saw that the service was accredited through the Royal College of Psychiatrists for the Accreditation for Inpatient Mental Health Services (AIMS) for Rehabilitation. This accreditation recognises high standards of organisation and care and this included a peer review of the service. Leaders used this to help make improvements to the quality of the service.

Our findings

Engagement

People and those important to them worked with managers and staff to develop and improve the service. Feedback was captured from people regularly at the weekly ward community meetings and through ward rounds. We saw evidence of community meeting minutes where people fed back suggestions and ideas. All people were invited to the community meetings. People told us that they also had surveys regularly to provide feedback. The ward used a "you said, we did" format for recording feedback from people using the service. The responses seen on these were dated 2021 and 2022 so were not up to date.

The service held formal listening events for family and friends to share their views and discuss issues with staff. The service used comments to improve the service. Staff actively sought the views of carers via the family engagement and liaison lead who held carers forums to enable carers to communicate feedback informally. They also provided them with the NHS Friends and Family Test (FFT) which is part of the Patient Reported Experience Measure (PREM) and provided carers and relatives the opportunity to engage.

Leaders told us that they had representative roles for those using the service. This involved people using the service applying for and receiving training for this role. Quarterly, these representatives and carer representatives joined the clinical governance meetings. The service provided easy read minutes and agendas for these meetings.

The service also sought feedback from staff which included a yearly staff survey, team meetings and more local supervision processes.

Managers engaged with other local health and social care providers and participated in the work of the local transforming care partnership. Managers ensured that each person had regular CPA and C(E)TR meetings. They participated in these and shared information about the person to inform these. Staff worked with providers where people had previously lived or were moving to which helped ensure the best outcome for the person.

Learning, continuous improvement and innovation

The service's quality and governance structures, which included recommendations from audits, complaints and learning from incidents ensured that improvements were made as a result. The themes or particular aspects of learning were also taken to Directorate meetings and to the Trust wide Patient Experience Group to highlight the issues and what action had been taken to ensure accountability.

Leaders had a clear vision for the direction of the service which demonstrated ambition and desire for people to achieve the best outcomes possible. The service were using the standards under the National Autistic Society Accreditation (NASA) to guide their vision in improving the service to enable better outcomes for people. Some leaders and staff told us about initial plans to make changes to the environment. Some leaders and staff told us about initial plans to make changes to the environment. The Trust were carrying out sensory environment audits to see what areas of improvement were needed, as well as identifying existing good practice. People using the service were invited to these audits and on the working groups where these plans were being made, so that they were involved in providing input and feedback in the changes to the current environment. The Trust also told us that they had plans to have sensory leads on the ward.

Psychology staff were also engaged in a number of research projects linked in with local universities. The service was a research pilot site for sex offender treatment for men with a learning disability and the use of Eye Movement Desensitisation and Reprocessing (EDMR) psychotherapy on people with a learning disability. Staff were also carrying out research on staff experiences of racism at work. Several staff working for the service contributed to a recently published collective of research on working with people with autism in the Criminal Justice System.

Our findings

Some staff told us that due the current financial climate, the Trust had put in place a wellbeing hub to assist with wellness, staff retention, and to provide advice and guidance to help them financially, such as foodbanks. The service also held regular team days for the staff on the ward.

Our findings

Outstanding practice

We found the following outstanding practice:

- The service worked closely with people using the service to design and deliver training.
- The service also used restorative practice to help manage conflict and resolve incidents on the ward. Restorative practice brings those harmed by conflict and those responsible for the harm into communication, enabling everyone affected by a particular incident to play a part in repairing the harm and finding a positive way forward. They have been accredited for their work with this.
- The service had an anti-racism working group with various projects including development of the Active Allyship Group and programme. The latter, which was agreed by people using the service, involved specific care plans, and a report to the police for individuals who displayed racist behaviour. This was to address the racial abuse received by staff working with people on the wards.
- The service was a research pilot site for sex offender treatment for men with a learning disability and the use of Eye Movement Desensitisation and Reprocessing (EDMR) psychotherapy on people with a learning disability.
- Staff were also carrying out research on staff experiences of racism at work.
- Staff recently published collective research on working with people with autism in the Criminal Justice System. This was something staff were proud of and reinforced what they were doing in the service themselves.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that all staff complete their immediate life support training and that there is always a member of staff with this completed training on shift. (Regulation 12: Safe care and treatment)
- The service must ensure that all staff working with people with a learning disability and autistic people receive mandatory training as a legal requirement, so they are competent and equipped with the essential knowledge and skills to understand and work with the specific needs of people using the service. (Regulation 18: Staffing)

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure it has appropriate storage for medicines requiring refrigeration on the ward storage safely on the ward.
- The service should ensure fire risk assessments in place for people prescribed paraffin-based skin products.

Our findings

- The service should ensure that the external gardens are free from any items that are broken or disused.
- The service should make improvements to the efficiency of finding necessary information stored within peoples care records.
- The service should consider whether the restrictions to garden access are necessary and proportionate for all people.
- The service should explore ways to better improve the interaction from staff towards people, including at mealtimes.
- The service should ensure improvements are made to the sensory environment, such as notice boards and reduction of noise (doors), to make this more accessible and comfortable for people using the service.
- The service should improve the recorded involvement of people within nursing care plans.

Our inspection team

The team that inspected this core service comprised of four CQC inspectors (two mental health inspectors, one of which was a registered learning disability nurse with experience of working in similar settings, and two medicines inspectors) and one specialist advisor. The specialist advisor had experience working with people with learning disability and autistic people. These visits were carried out across three days over two weeks. A CQC Mental Health Act Reviewer (MHAR) also carried out a focused mental health act review of Brookfield centre.

During this inspection we considered aspects of the following key questions:

- 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 the hospital.

During the inspection visit, the inspection team:

- undertook a tour to look at the quality of the ward environment
- spoke with eight out of 12 people who use the service
- spoke with three carers/ relatives by telephone
- observed a group activity for Autism Awareness Week and other leisure activities on the ward
- carried out direct observations of care using the Short Observational Framework for inspection (SOFi). SOFi is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe this themselves because of cognitive or other problems. It enables inspectors to observe people's care or treatment looking particularly at staff interactions
- looked at 7 care records
- looked at 7 prescription charts and inspected clinic and treatment rooms
- attended and observed a Multidisciplinary Team (MDT) handover meeting
- spoke with 20 members of staff including nurses, healthcare support workers, an occupational therapist, ward manager, matron, team leader, responsible clinician, principal clinical psychologist, ward pharmacist, lead for e-meds (medication system), lead forensic social worker and compliance and governance lead
- reviewed a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing