Bostall House

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

We rated Bostall House as good because:

- We saw staff delivering care with kindness and respect. Patients told us that staff helped them to make decisions about their care and that they felt safe. The service regularly collected feedback from patients and this feedback was positive. Staff supported patients to meet their religious and cultural needs.
- Staff completed comprehensive assessments when patients were admitted to the service and developed a number of care plans for each patient's different needs.
- Staff used verbal de-escalation and low-level guided restraint techniques on the ward. The ward did not use high numbers of bank and agency staff.
- Several staff described positive changes that the new manager had brought to the service since they started in March 2015 and described morale as high. This was reflected in staff satisfaction surveys. The new ward manager had identified training needs of staff and was in the process of arranging this. Training rates were over 75% for all mandatory training.
- The ward and clinic room was clean and tidy and medicines management was safe and appropriate.

However:

- Not all risks identified in patients' risk assessments had plans in place to reduce them.
- Staff had not made sure that all records of patients' ongoing physical health checks were in place.
- The service had not told the Care Quality Commission (CQC) about three reportable incidents in 2015.
- Patients did not have access to an advocate or independent mental health advocate (IMHA).
- The garden posed some environmental risks that the service had not identified.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Good 	

Summary of findings

Contents

Good

Location name here

Services we looked at
Wards for people with learning disabilities or autism

Summary of this inspection

Our inspection team

Team Leader: Natalie Austin Parsons, Care Quality Commission.

The team that inspected Bostall House consisted of one CQC inspector, one CQC inspection manager, one expert by experience with experience of using learning disability services, one specialist advisor for learning disability services, and a Mental Health Act reviewer.

Why we carried out this inspection

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

How we carried out this inspection

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

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

During this inspection visit, the inspection team:

- visited Bostall House and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with four patients who use the service
- spoke with the ward manager
- spoke with the operational manager
- spoke with nine staff members, including three nurses, three support workers, an activities co-ordinator, a consultant psychiatrist and a forensic psychologist
- looked at all six treatment records of patients
- carried out a check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Bostall House

Bostall House is a six-bed independent hospital located in Abbey Wood, London. The service provides assessment and treatment for men living with a learning disability and associated complex needs. Bostall House had a scheduled, planned CQC inspection in September 2013. This inspection found that the service needed to take action to meet three unmet care standards. These were care and welfare of people who use the services, safety and suitability of premises and assessing and monitoring the quality of service provision. At a follow up inspection in February 2014, the service had made the necessary changes to meet these standards.

Summary of this inspection

What people who use the service say

The patients we spoke to during the inspection said they felt safe on the ward. They said they were well looked after and that nurses were kind and helpful. Patients had a good understanding of their care plans and said staff supported them to make decisions about their care.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- In two case records, a risk identified on a risk assessment form was not reflected in the care plan. There was no clear reason recorded as to why or how the service would manage the identified risk.
- The inspection team identified the steps in the rear garden as an environmental risk as they were very steep. The service had not identified the fence in the rear garden as a ligature risk.
- The service policy stated that a designated area should be identified for children and young people if they visited patients and they should not be accessing communal areas on the ward. This was not reflected in practice.

However:

- The clinic room was visibly clean and in order and staff checked the resuscitation equipment once a day.
- The ward had a low use of bank and agency staff. All shifts were filled in October and November 2015 with the correct number of staff working. Staff felt the rota was well managed and staffing levels were adequate to meet the needs of the patients.
- Staff had a clear understanding of restraint and recorded their use of it appropriately. Guided restraint was the most common form of restraint used on the ward. Staff reported that there had been a reduction in the use of restraint in the last two years.

Are services effective?

Good

We rated effective as good because:

- Staff completed a comprehensive assessment for each patient on admission, including physical health examinations.
- Each patient had a number of care plans for their different needs. All care plans were personalised and recovery orientated.
- Ward staff and the forensic psychologist used a number of recognised tools to assess and record severity and outcomes for patients. A lot of these tools were adapted for use with people with a learning disability.
- Staff felt supported and the ward manager had introduced formal supervision when they started in March 2015.
- Handovers between nursing and support staff took place between each shift and were recorded well.

However:

Summary of this inspection

- Not all patients had access to an advocate or independent mental health advocate (IMHA).
- For one patient, there was no record of regular physical health checks taking place, despite this being identified as needed in their initial physical health assessment.

Are services caring?

Good

We rated caring as good because:

- We saw staff deliver care with kindness and respect.
- Staff showed a detailed knowledge of patients and patients told us they got along with staff and that they felt safe.
- Patients completed regular, easy-read feedback surveys about the service and their feedback was positive.
- Patients were happy with their care plans and said that staff helped them to make decisions about their care.
- Staff helped patients to be involved in planning the food menu and there were easy-read tools for patients to make daily food choices. The provider held regular service user forums that patients could attend.

Are services responsive?

Good

We rated responsive as good because:

- Patients could regularly go to their place of worship and practice their religion on the ward. The service provided food in line with religious needs.
- An on-site chef prepared all meals and there was a choice of food at meal times.
- There was a full-time activities co-ordinator for the ward and they ran a full timetable of activities that patients were happy with. These activities were supportive of integration with the local community. The hospital provided care which was orientated towards successfully discharging patients.
- Patients were able to personalise their bedrooms and had access to spacious, well-kept front and rear gardens.

However:

- Patients did not have access to lockable place in their bedrooms for personal possessions.
- There was a limited amount of easy-read information available about physical health support. Patients did not have direct access to hot drink making facilities.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- There were regular clinical and corporate governance meetings, and health and safety meetings. The ward manager had access to the risk register, completed it appropriately and was able to update it when necessary.
- The service regularly conducted clinical audits, which had action plans that the ward manager updated.
- Staff were aware of the how to report incidents within their organisation and were doing this correctly.
- Staff felt supported in their roles by their peers and management.
- Several Staff described morale as high and that it had improved since the start of the new manager in March 2015. Several staff described positive changes that the new manager had brought to the service.

However:

- The service had not notified the CQC of three reportable incidents in 2015.
- In a recent clinical records audit, monitoring forms were not included next to specific care plans. This was still the case for one patient during the inspection: they had a physical healthcare plan in place, but monitoring records for a regular health test were not available.
- The organisation's governance team stated they carry out annual, internal quality development reviews on each ward. The last one was carried out in February 2014, so there has not been one carried out on this ward since then.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Staff were able to access training in the MHA. Staff had carried out good capacity assessments and the consultant psychiatrist had requested a second opinion approved doctor (SOAD) in accordance with the MHA Code of Practice. Patients were informed of their rights and status under section 132 of the MHA on admission and understood their status and their rights. Staff made statutory referrals to tribunals and supported patients to attend. All leave under section 17 of the MHA was properly authorised.
- Patients did not have access to an independent mental health advocate (IMHA). The ward manager had placed this on the service risk register and sought access to an IMHA through each patient's local community team.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to access training in the Mental Capacity Act (MCA) and the trust policy on the MCA and Deprivation of Liberty Safeguards (DoLS). There was an action plan in place to ensure all staff received this training. Patient records contained information that related to capacity and consent.
- Staff carried out a financial capacity assessment with one patient where they felt it appropriate.
- At the time of the inspection there were no patients subject to an authorised DoLS. The ward manager had made one DoLS application in the last six months and had a good understanding of the process.

Good

Wards for people with learning disabilities or autism

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- The ward layout provided staff with clear lines of sight for patients in the communal areas. Staff could also observe patients in communal areas on CCTV. However, the staircase from the ground floor to the first floor bedroom area was narrow and did not allow for clear lines of sight. There was one blind spot on the staircase that was not covered by convex mirrors so patients and staff could not see who was using the stairs. There were no plans in place to manage this risk.
- Staff completed a monthly ligature risk audit of the ward. The last audit, completed on 30 September 2015, identified potential ligature points on the ward and outlined how staff would manage these locally. The fence in the back garden presented a ligature risk although this was not identified by the service. Staff reported that they supervised patients' access to the garden at all times.
- Staff carried out medicines management well. The clinic room was visibly clean and tidy. Staff checked and recorded its temperature regularly. The drugs cupboard was in order and records showed a qualified nurse signed for drug deliveries. The drugs fridge was not in use at the time. Controlled drugs were stored appropriately and staff completed appropriate paperwork. A controlled drugs audit carried out in May 2015 showed a score of 91% in line with correct practice. The ward manager had marked the three incomplete items from the audit as completed in June 2015. Training records showed that three nurses out of seven were trained in medicines management. The clinic room was equipped with blood pressure and blood sugar monitors.
- There was no examination couch in the clinic room. If required, staff told us examinations would take place in patients' bedrooms.
- Resuscitation equipment was kept on the ground floor next to the nursing office which was close to the communal ward areas in the day. Records showed staff checked the emergency equipment daily.
- The ward was clean and the corridors were clear and free of clutter. An area of the first floor landing was being redecorated during the inspection. In one bedroom there was a wardrobe door missing. The ward manager told us that they had ordered a new wardrobe door. The patient was aware of this. Staff told us that maintenance staff responded quickly when an issue was raised.
- Three patients completed easy-read feedback surveys in September and April 2015 which included questions about the environment of the ward. There were several questions about the environment and patients marked they were happy with the environment across 77% of these questions in both April and September.
- A patient from a different learning disability ward within the same provider, with the support of staff carried out a patient-led assessment of the care environment (PLACE). Their feedback was that the carpets were old and that there was a lack of pictures in the ward area. The inspection team noted the lack of pictures as well.

- The ward housekeeper followed a cleaning schedule and was on the ward from 8am to 4pm, Monday to Friday. The schedule was clear, gave details about which areas to clean and the housekeeper marked the schedule as completed daily. The service did not have a member of domestic staff to cover the weekends and there were no arrangements for the environment to be cleaned over the weekends.
- Alcohol gel was accessible at the entrance to ward.
- The service carried out an environmental risk assessment each month, most recently in November 2015. The steps in the back garden were steep and could cause a risk of slipping. This had not been identified in the environmental risk assessment.
- All staff had access to personal alarms, which they tested each day before their shift started.

Safe staffing

- There were 12-hour day and night shifts for nursing staff with an additional half an hour for a handover between shifts. During the day, one qualified nurse worked alongside four support workers. During the night, one qualified nurse worked alongside two support workers. This staffing pattern was in place when the ward manager started in March 2015 and they had not felt it necessary to review it.
- There were no vacancies in nursing and support staff. All shifts for October and November 2015 were filled, which meant the right number of staff were at work for each shift. Two staff members told us that staffing numbers were generally good and that the rota was well managed.
- The ward had a low use of bank and agency staff. In November 2015, no bank or agency staff worked any shifts. In October 2015, two bank staff worked one 12-hour shift each.
- Patients had regular leave and access to the community. Leave was not regularly cancelled due to staff shortages.
- The consultant psychiatrist attended the ward two days a week. An on-call doctor could be contacted by phone at all times, including out-of-hours. Two consultant psychiatrists provided the on-site and on-call cover for four units, including this one, within the organisation.
- The ward manager recorded and managed information on training rates using a training matrix. The ward manager told us that they had focused on increasing the number of staff completing their mandatory training since taking on this role in March 2015. Mandatory training rates for staff was over 75% in all areas.

Assessing and managing risk to patients and staff

- Staff received training in physical intervention. All nursing and support staff had completed a four-day, full physical intervention Maybo course. In the last six months, staff had only used guided restraint techniques and had recorded this appropriately. Staff told us they used a number of communication and de-escalation techniques before using guided restraint. Staff described how they pro-actively dealt with challenging behaviours, starting with good communication and using their knowledge of individual patients. Staff told us there was less restraint used now on the ward than there was one to two years ago. Staff had not used rapid tranquilisation in the last six months. Staff had not used seclusion in the last six months.
- An external pharmacy supplied medicines to the ward and carried out an annual audit of medication each year. Staff had completed all six patients' medication charts fully.
- There were no rooms off the ward where children could visit patients. Staff told us that patients used the lounge and dining room when they had visitors, which could include children. This was not in line with the service policy which stated a designated area should be identified for visits and children and young people should not be accessing communal areas on the ward.
- Staff completed an individual risk assessment for each person on admission using an organisation-wide risk assessment form. Staff described risk assessment as an ongoing process for each patient. As the service routinely took planned admissions, staff said they could carry out these assessments before the patient arrived at the ward.
- Each patient had individual risks identified in their risk assessments. For two patients, staff had not produced plans to respond to a risk identified in the initial

assessment. This could impact on the safety of the patient as well as staff and other patients. All other risks outlined for these individual patients, as well as others using the service, were addressed in a care plan.

- One patient had a physical health condition identified on admission but their care plan for this was not available in their file. This care plan was in the nursing office, but not stored correctly in their file. This plan was noted as missing from the file in a clinical records keeping audit from September 2015. Another patient's physical health care plan outlined one regular test needed to take place. Records for this test being carried out were not available.
- Staff assessed prohibited items for each individual patient in relation to risk assessments and there was an example of one patients' prohibited items being updated following an incident.
- Each patient had a personal emergency evacuation plan.
- There was a notice near the front door saying that informal patients could leave at will and who to speak to about this.

Track record on safety

- The service had an adult safeguarding policy and an internal reporting system for serious incidents, which included safeguarding incidents. On review of the information we received from the organisation, we found there had been four serious incidents in the last 12 months. The ward manager had recorded these on the internal serious incident database. The service had not notified CQC of all the reportable incidents in 2015. Incidents taking place from October 2015 onwards were reported appropriately.

Reporting incidents and learning from when things go wrong

- Staff were aware of how to report an incident using the organisation's new reporting system, Ulysses. The ward manager reviewed all incidents and they were also discussed at the multidisciplinary team meeting each week. The new system allowed each member of staff involved in an incident, as well as the patient, to add to the record. A qualified nurse signed off each record. Staff would also offer a debrief to patients after incidents. Staff said that although incidents were reported appropriately, feedback to the team enabling learning from incidents did not always take place.
- A member of staff at the organisation's head office was responsible for conducting root cause analysis on serious incidents and feeding this information back to the service. Staff told us they would then use this information to make improvements to care plans.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Clinical staff completed a comprehensive assessment for each patient on admission. There was a holistic approach to assessment and individual care plans were developed in line with individual needs. Staff developed care plans for the different needs of each patient, for example individual physical health conditions.
- Staff told us that the patient mix was appropriate where assessments were done thoroughly before an admission. The service currently had one person who was admitted as an emergency. The staff identified that the service did not fully meet their needs to support non-verbal communication and had sourced another, more suitable placement.
- All six care records included a physical health examination that staff had carried out on admission. All patients were registered with the local GP. Staff told us they felt there was a good working relationship between themselves and the local GP. The staff we spoke to were aware of the individual physical health needs of the six patients on the ward.
- Care records contained the date of admission and observation levels, a risk assessment and initial assessment for capacity, completed by the consultant psychiatrist. They also contained a risk assessment tool for falls and scores from the Health of the Nation Outcome Scales for People with Learning Disabilities (HONOS-LD).

- Each patient had different care plans for their different needs. These included a physical intervention protocol, a mental health and wellbeing care plan, physical health care plans for specific conditions and a "My Day" plan. The "My Day" plans outlined each individual's preferred activities. Each patient also had a dental hygiene plan, a personal activities schedule and a PRN (as required) medication protocol. PRN medication is medication that is taken when needed for a particular condition. Nurses completed daily updated notes against each care plan for each patient.
- Each patient also had a person centred file. This included a missing person's pack, a communication passport including the views of the patient, information about people who were important to the patient, a health action plan, a health passport for visits to hospital and a safety support plan.
- All care plans were personalised and recovery orientated, with identified strengths and goals.
- In the provider clinical records audit from September 2015, of the two files audited, monitoring forms were not included next to specific care plans. This was still the case for one patient during the inspection: they had a physical health care plan in place, but monitoring records for a regular health test were not available.

Best practice in treatment and care

- The consultant psychiatrist told us that the staff team received email alerts about National Institute for Health and Care Excellence (NICE) guidelines for medication and therapies. Patients had access to a forensic psychologist who told us that patients were offered one-to-one psychological interventions, individual to their needs. These interventions included particular skills and strategies, awareness training and anger management.
- The consultant psychiatrist followed the correct procedure for requesting a second opinion appointed doctor (SOAD) when medication was prescribed above guidelines.
- Ward staff and the forensic psychologist used a number of recognised tools to assess and record severity and outcomes for patients. This included the HONOS-LD, which covers 18 health and social domains and enables the clinician to build up a picture over time of the patients' responses to interventions. The psychologist also used Clinical Outcomes in Routine Evaluation for Learning Disabilities (CORE-LD) at the start and end of treatment. CORE-LD is a validated self-report outcome measure for people receiving any form of physiological therapy and measures psychological distress. The psychologist also told us they used The Beck Anxiety and Depression Scale, the Personality Assessment Inventory, the Inventory of Sex Offender Needs and My Relationship History. One of the staff was also a Life Star Champion and completed the Life Star tool with all patients. Life Star is a tool to develop and support positive behaviour interventions.
- The service followed the organisation's auditing schedule and regularly conducted a number of audits. The organisation developed their own forms and included audits on the Mental Health Act (MHA), confidentiality, medication, physical health needs and service users' money. In total, the service carried out 13 audits in 2015. All audits were scored for their compliance with good practice and had action plans that were regularly updated by the ward manager. Two consultant psychiatrists who worked across the organisation's four units in South East region of England conducted several audits. The ward manager told us they visited the provider's other learning disability service in the South East region to share learning.

Skilled staff to deliver care

- As well as nursing staff, a consultant psychiatrist, forensic psychologist and activities-coordinator provided input to the ward. The psychiatrist and forensic psychologist each provided input two days a week. The activities co-ordinator provided input from 8am to 4pm, Monday to Friday and aimed to work one weekend a month. An occupational therapist left the service in August 2015. The ward manager was in the process of recruiting a new occupational therapist.
- There was no speech and language therapist employed by the provider. Where there had been a very clear need for a patient, input was purchased from an external service. Staff told us that this had taken place for two patients.
- The forensic psychologist was new to the service and the staff team were positive about the input they had

provided so far. Staff also told us it was also a positive that there was now a consistent manager in place. Nursing staff we spoke to told us they felt that staff in the multidisciplinary team were accessible.

- The new ward manager had introduced regular supervision and staff told us that they received individual supervision every eight weeks or more regularly if requested. There was a supervision tree in place and supervision was recorded. Supervision records indicated that between March and October 2015, three staff received supervision four times, 15 staff received supervision three times, three staff received supervision twice, one staff member received supervision once and two staff had not received supervision. Of non-medical staff, 82% had received an appraisal in the last 12 months.
- There was a team meeting schedule in place and these happened monthly.
- The ward manager and staff we spoke to told us that staff had received training in basic Makaton. Makaton uses signs and symbols to help people communicate and is used widely with people with a learning disability. It was also confirmed that the activities co-ordinator would be completing full Makaton training in January 2016.
- The service had confirmed funding for one person to complete a master's degree in positive behaviour support (PBS), and had selected a mentor from the staff group. This was in addition to 12 staff members having had training in PBS. PBS emphasises respect for the individual being supported and aims to increase personal skills and competencies. PBS approaches are included in authoritative guidance for working with people with learning disabilities who exhibit behaviours described as challenging. This authoritative guidance includes that from the Department of Health, The British Psychological Society and the Royal College of Speech and Language Therapists.
- The forensic psychologist told us that they planned to develop and deliver a number of in-house training sessions for the staff team in relation to supporting people with a learning disability and to enhance staff understanding of PBS. They had already introduced the traffic light technique to patients, which helped them to communicate how they felt with signs.
- These training plans were clear but not yet in place. One patient had specific communication needs that the staff team were not adequately trained to meet. The ward manager had found a more appropriate placement for this individual, but while they were at this service, this meant their needs were not being met.

Multi-disciplinary and inter-agency team work

- A multidisciplinary meeting took place once a week. Staff discussed two patients a week at the meeting, which lasted up to four hours. Staff told us that they felt this process could be more efficient. They felt that it would be helpful to discuss each patient more frequently and that staff were spending an unnecessary amount of time in this meeting, reducing the time they had for clinical work.
- Patients were encouraged to attend the weekly multidisciplinary meetings to have an input into decisions about their care.
- Staff handovers between nursing shifts took place twice a day between the day and night shift. Each handover was 30 minutes long and staff told us they enabled good communication. Handover records were competed for each patient at the change of each shift. The records outlined patients' positive achievements, areas of concern and levels of observations.

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

- Seven staff (22%) had training in the Mental Health Act (MHA). The ward manager told us they identified this as an area of need when they started in March 2015 and had provided training to all qualified nurses in October 2015. The ward had a copy of the new MHA Code of Practice.
- Consent to treatment under section 58 of the MHA was in order and staff had carried out capacity assessments. The consultant psychiatrist had requested a second opinion approved doctor (SOAD) in accordance with the MHA Code of Practice.
- Patients said they were informed of their rights and status under section 132 of the MHA on admission. Staff made repeated attempts to ensure patients' understanding. Detained patients understood their status and their rights.

Good

Wards for people with learning disabilities or autism

- Records showed that patients were attending tribunals and hospital managers' hearings. Statutory referrals to tribunals were in order.
- All leave under section 17 of the MHA was properly authorised. Pre-leave assessments were good and completed thoroughly. The patients had leave for leisure and education. The documentation for transfers to the unit was correct.
- Approved mental health professional reports were present and in order.
- Patients did not have access to an independent mental health advocate (IMHA). IMHAs are specialist advocates who are trained to work within the framework of the MHA and can support patients to participate in decision-making.
- The ward manager placed the lack of access to an IMHA on the service risk register in August 2015. The ward manager had sought access to an IMHA through each patient's local community team. This led to IMHA services being provided to two patients from their local community team. For the remaining patients, local community team had not provided access to an IMHA. The MHA Code of Practice outlines that it is the responsibility for a patient's local authority to ensure that timely access to an IMHA is available in chapter 1 12.

Good practice in applying the Mental Capacity Act

- Sixteen staff (50%) had training in the Mental Capacity Act (MCA). Information about the MCA was displayed on the ward. The ward manager told us they identified this as an area of need when they started in March 2015 and provided training to staff. Staff said the training had been helpful to increase their confidence in working with the MCA.
- The organisation had a Deprivation of Liberty Safeguards (DoLS) policy dated January 2015. There was one DoLS application made in the last six months. The ward manager made this application on the 17 September 2015 and was waiting for an assessment by the local authority to take place at the time of the inspection.
- Staff carried out a financial capacity assessment with one patient where they felt it appropriate.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- We observed interactions between staff and patients which were supportive and caring and which displayed an understanding of individual patient needs. There was a good rapport between patients and staff. Staff displayed respect and an understanding of patients' personal preferences, for example telling us that one person might want to speak to us but would not want us to see them in their room.
- Patients told us they got along with staff. Patients at the service completed an easy-read feedback survey in September 2015, where responses could be chosen from happy, unsure and unhappy. In response to several questions about staff, 98% of answers were happy and 2% as unsure. In response to several questions about care and treatment, 89% of responses were happy.

The involvement of people in the care that they receive

- The service had an easy-read information pack about the service available on their website.
- Three patients told us they were happy with their care plan and that staff supported them to make decisions about it. Patients had an understanding of what was in their care plan and who contributed to it.
- Patients did not have access to an advocate. Advocates are people independent of an organisation who can support a patient to get information and express their concerns. The ward manager placed the lack of access to an advocate on the service risk register in August 2015.
- Two patients told us about the involvement of their family in their care and when they visited. Staff told us they regularly liaised with family members. Patients were supported to visit their families using the service bus.
- Staff regularly supported patients to complete easy-read service user satisfaction questionnaires to gain their

feedback. The last was one was completed in September 2015. At that time, one patient noted that they did not want to complete the form. Questions covered satisfaction with activities, feeling safe, the ward environment and care and medication. Before this, a service user satisfaction questionnaire was completed in April 2015.

- Staff facilitated daily patient group meetings where patients could give feedback about the service and talk about the day's plan. Fortnightly service user empowerment meetings also took place. Staff took minutes of these in an easy-read format.
- Staff supported patients to be involved in planning the food menu. Staff also used easy-read tools at each meal to allow patients to choose what they would like to eat.
- The organisation had a quarterly regional service user forum for their four services in the South East region of England. The last meeting was on 27 August 2015. Representatives from each service were able to attend and give feedback. There were easy-read minutes for these meetings from May and August 2015. The organisation also held a national forum for all of their services across England, which could be attended by patients and families. The last one took place on 11 June 2015.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

- Average bed occupancy from April to September 2015 was 95%, with occupancy rates of 100% from June to September 2015.
- Patients were referred and transferred from other mental health units. Clinical staff undertook assessments before admission in most cases. This allowed them to assess the suitability of the admission considering their staff skill mix and current patient mix on the ward.
- When an inappropriate admission had taken place and the staff could not meet the needs of the patient or the patient mix became unsettled, staff had recognised this and sourced a more appropriate inpatient placement. This was the case for the last emergency admission where staff could not meet the communication needs of the patient. Following this situation, the provider had not developed clear guidelines around who could or could not be accepted to the service.
- Staff discharged patients to alternative inpatient placements or to supported living accommodation. One patient had recently been discharged to supported living accommodation. The average length of stay for patients in the 12 months before the inspection was 12-18 months. This is less than the mean length of stay for patients outlined in the 2013 Learning Disability Census, which was just under three years.
- In the last six months there were two delayed discharges from the ward. These were delayed as the service was waiting for new placements to be found for two patients.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a clinic room, a lounge, an activities room, a dining room and kitchen where an on-site chef prepared the meals. The ward also had access to a front and rear garden which were spacious and had a trampoline and picnic benches. All bedrooms were en-suite. The ward did not have a low-stimulus room for patients.
- The service had a small bus and driver available to support patients to attend physical health appointments where necessary. Where appropriate, staff told us they supported patients to take public transport to appointments to encourage independence.
- Staff reported that the activities room was used as a space where patients could meet visitors. The lounge and gardens were also used if necessary and appropriate.
- Some patients had access to their own phones. This was assessed on an individual basis. The ward had a cordless phone that patients were able use in private if they receive a call and did not have access to their own phone.

Good

Wards for people with learning disabilities or autism

- The on-site chef prepared all meals and there was a board with a visual display of options for each meal, including vegetarian choices. Staff told us that each week the chef would discuss with patients what they would like to eat and that there was an emphasis on nutrition as well as what people wanted.
- Five patients completed an easy-read food survey in 2015. Three people said they liked the food on the menu. One person was unsure and one person did not like the food on the menu.
- Patients did not have access to the kitchen to make hot drinks. Patient snacks were stored in containers in the staff room and patients asked a staff member for these when they wanted. Staff said patients could request hot drinks and snacks at any time. Of five patients that completed the food survey in 2015, all said they could have a snack during the night if they wanted one.
- Patients could personalise their bedrooms and access them at all times during the day. Some patients had keys to their bedrooms. This was assessed on an individual basis.
- There was a safe in the nursing office where patients could keep some personal possessions, but there was no access to a safe in bedrooms.
- Activities for patients were available daily and over the weekend. The ward had an activities co-ordinator Monday to Friday, 8am to 4pm, and one weekend a month. Staff told us that there were a number of activities that took place, including outings for the group and individuals. The activities co-ordinator was able to outline recovery focussed group and individual activities planned each week, for example the group visited a café together weekly as well as did activities individually that they enjoyed.
- Three patients completed an easy-read service user satisfaction questionnaire in September 2015. Patients chose responses from happy, unsure and unhappy. When asked about the activities available to them, 95% of responses were marked as happy.
- Three patients told us about the activities they do, what they enjoy, and about their "My Day" plan. The "My Day" plans were a record of each patient's preferred activities. All six care records for patients had their "My Day" plans present.

Meeting the needs of all people who use the service

- There was a lift available to access the first floor bedroom area from the first floor for those requiring disabled access. There was one bedroom with wider doors to allow access to the room.
- Easy-read information about the service was available on the service website. There was also easy-read information about medication in patients' files which was based on the University of Birmingham medicine information for people with learning disabilities. There were also easy-read documents for care programme approach (CPA) meetings in patients' files. Service user feedback questionnaires and outcome measures were adapted for use by people with a learning disability.
- The dining room wall had a menu for the week which included visual aids. There were pictures of staff and their names on a notice board.
- There was a limited amount of easy-read information about physical health support available on the ward.
- Patients were supported to visit their place of worship on a weekly basis. Patients as well as staff told us that patients had access to appropriate spiritual support, including access to a choice of food that met religious requirements.

Listening to and learning from concerns and complaints

- Information about the complaints procedure was available on the ward information board and the provider had an easy-read information booklet on how to make a complaint. Two patients said that they had confidence that any complaint they made would be taken seriously.
- There were two complaints made in the service in the last 12 months. Both were responded to appropriately and neither of these complaints was upheld.

Are wards for people with learning disabilities or autism well-led?

Good

Vision and values

Good

Wards for people with learning disabilities or autism

- Staff displayed a good understand of the vision and values of the organisation, developing relationships based on empathy, kindness and respect, communicating with patients about their care and displayed a commitment to their work.
- The service manager displayed clear knowledge and understanding of the ward and areas where improvements could be made, for example increased input from a speech and language therapist.

Good governance

- There were clear governance structures in place within the organisation. Clinical and corporate governance meetings took place every two months. The corporate governance meeting was located in York. A representative from the multidisciplinary team attended this and fed information back to the wider team. A health and safety meeting also took place every two months. A meeting for consultant psychiatrists within the organisation took place every three months. The ward manager had access to information about staffing levels and training and supervision records.
- The service followed the organisation's auditing schedule and regularly conducted a number of audits. There was one example where an audit did not lead to improving the quality and safety of care for patients.
- The ward manager had access to the risk register, completed it appropriately and was able to update it when necessary.

Leadership, morale and staff engagement

- Eight staff completed a staff engagement survey in November 2015. All eight answered that they agreed with statements about feeling their opinion was valued, feeling supported, being able to develop, having good team communication, being able to regularly talk to their supervisor, feeling concerns were taken seriously and would recommend working at the service.
- The ward manager monitored staff sickness rates. This was 13.6% for all permanent staff (up to 10 September 2015).
- Information about the whistleblowing procedure was displayed on the ward. The whistleblowing policy was last updated in May 2015. All staff told us they felt able to raise concerns.
- Staff described morale as high and that it had been improving since the start of the new manager in March 2015. Staff told us they felt supported from both management and peers and said they were happy to work at the service. Several staff described positive changes that the new manager had brought to the service, for example daily service user meetings, a tidier clinic room and updated notice board in the ward area. The ward manager also felt there was a good staff team.
- The service had a 'champions' scheme in place. This meant different areas, such as health and safety, had a lead who attended specialist training and acted as an expert in their chosen area.

Commitment to quality improvement and innovation

- The organisation's governance team carried out annual internal quality development reviews on each ward. This involved an unannounced visit by a team of experts that included people external to the organisation and representation from a service user. The governance team developed an action plan from this review, which the ward manager was responsible for updating each month. The plans clearly outlined what action needed to take place, who was responsible for doing it and when this needed to be done by. The plan outlined 70 separate actions to be taken. Every action except one, where service users have access to an independent mental health advocate (IMHA), was marked as complete. The action plan supplied by the service was dated 11 February 2014. This meant there had not been a review between February 2014 and November 2015.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that risks identified in risk assessments are appropriately managed, for example by being covered in patient care plans.
- The provider must ensure that physical health interventions are carried out and recorded when they have been identified as necessary.
- The provider must ensure they submit all required statutory notifications to the CQC.

Action the provider SHOULD take to improve

- The provider should ensure that all patients have access to an advocate and that patients who are detained under the Mental Health Act have access to an independent mental health advocate.
- The provider should ensure the steps in the rear garden are assessed for their safety and any necessary changes made to them.
- The provider should ensure that practice around children and young people visiting the ward reflects their policy, or ensure that there is a local or updated policy in place which outlines how appropriate supervision takes place on the ward during visits.
- The provider should ensure there is sufficient information available to patients about physical health support that may be relevant to them. This information should be available in an appropriate format, such as easy-read documentation.
- The provider should provide patients with facilities to securely store personal possessions in their bedrooms.

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 **Staff had not produced plans to respond to all risks identified in the initial risk assessment.** **Staff had not ensured that records of physical health tests, highlighted as necessary in an initial physical health assessment, had been completed.** This was a breach of regulation 12 (2) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had not submitted three statutory notifications to the CQC in the past 12 months.** This was a breach of Regulation 18 (2)(e)(f)