The Breightmet Centre for Autism

Quality Report

The Breightmet Centre for Autism
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Date of inspection visit: 4-5 June 2018
Date of publication: 06/08/2018

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?	Good
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.

Summary of findings

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

Overall summary

We rated Breightmet Centre for Autism as good because:

• Patients received comprehensive care assessments which involved input from a multidisciplinary team which including psychiatry, nursing, clinical psychology, occupational therapy. Care plans showed evidence of patient involvement in care planning, risk assessment and management and activity planning. There were sufficient nursing and support staff available to ensure patients were cared for in accordance to their care plans.

• Patients had access to physical healthcare and the service ensured their physical health needs were assessed and monitored on a regular basis. Patients with underlying physical health conditions had appropriate health action plans to monitor and manage these.

• We observed kind and respectful interactions between staff and patients. Both patients and carers gave positive feedback about how staff treated them. Staff knew the patients well and their needs.

• Patients could access telephone facilities within each apartment by either using their own mobile phone if this had been risk assessed or the cordless office telephone which could be used in their own bedrooms or in the quiet rooms.

• Patients had access to drinks and snacks throughout the day, with drink facilities kept on each apartment and snacks stored in the main kitchen.

• Patients had personalised activity planners, which were person-centred and designed to support their individual rehabilitation needs. Activities were available seven days a week both on and off site.

• There was an effective governance structure in place, which included systems and processes to ensure monitoring of the service. The provider was committed to service improvement. As well as having a comprehensive internal audit programme in place, the provider had commissioned a number of service specific reviews to ensure approaches and strategies were most appropriate for the patients within their care.

However:

• Although staff were aware of the processes in place for raising safeguarding concerns, the service manager did not immediately demonstrate that the threshold for these were understood when a concern was raised during the inspection.

• Though the service had psychiatry provision provided by a part time locum psychiatrist with the support from an assistant psychiatrist, there was no assurance to ensure all patients had received regular psychiatry assessments and reviews.

Summary of findings

Contents

Good

Location name here

Services we looked at:

Wards for people with learning disabilities or autism.

Summary of this inspection

Background to The Breightmet Centre for Autism

Situated in the Breightmet district of Bolton, Greater Manchester, the Breightmet Centre for Autism is an independent hospital run by ASC Healthcare limited. It is registered for the following regulated activities:

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

The centre provides enhanced services and support for up to 18 male and female adult patients with a learning disability and/or autism, who are either detained under the Mental Health Act or admitted informally. At the time of this inspection, all patients were detained under the Mental Health Act.

The service accommodation was divided into four separate apartments, located over two floors. The apartments consisted of four or five single bedroom suites with full ensuite facilities. Each contained a communal lounge, a dining room, a quiet room and access to an outdoor area. The apartments linked to the main annex which contained staff offices, a library, a kitchen, a multi faith room and a family visiting room.

The Breightmet Centre for Autism registered with the CQC in August 2013. There have been four previous inspections carried out at the centre. These included two routine inspections on 3 September 2013 and 30 January 2014, and an inspection in response to concerns on 14 August 2014. During the responsive inspection in 2014 we identified a number of areas of concern, which we then followed up with a routine inspection on 8 July 2015. It was determined the regulatory breaches identified in 2014 had been addressed, though a number of areas for improvement were identified.

These included the following recommendations for improvement:

- Staff should have a good understanding of patients' individual communication needs and utilise the appropriate tools and methods for communicating with the patient.
- The provider should meet individual patients' needs in a timely manner.
- The provider should ensure robust arrangements for comprehensive psychiatric cover.
- The provider should ensure clarity about the services it provides and the patient groups it supports. To achieve its vision of a highly specialist centre for autism, the service will need to further develop its focus on autism, and ensure staff receive additional specialist training on autism.

During this visit we found that the provider had taken positive steps to address these areas for improvement and continue to develop the service.

Our inspection team

The team that inspected the service comprised two CQC inspectors, an assistant CQC inspector and a variety of specialists: A specialist learning disability nurse, a nurse practitioner, and an expert by experience who was familiar with learning disability services.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we gathered information about the location from the provider.

During the inspection visit, the inspection team:

- visited all four inpatient areas at the hospital, looked at the quality of the environment and observed how staff interacted and cared for patients;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- spoke with eight patients;
- spoke with six relatives;
- interviewed members of the senior team including, the service manager, a deputy manager and the clinical nurse lead;
- spoke with the services multidisciplinary team including two qualified nurses, five support workers, a doctor, occupational therapists, a speech and language therapist, the psychologist and assistant psychologist;
- spoke with other staff from the service including, the Mental Health Act administrator, services advocate for autism, the human resources manager, the data assistant, the physical interventions trainer, a receptionist, a housekeeper, and the head of governance;
- interviewed a member of the board from the provider organisation, who had oversight for the service;
- spoke with the named contact at the local safeguarding authority;
- attended a shift handover;
- reviewed Mental Health Act records for nine patients, procedures and processes for the service
- looked at medication records for 18 patients and carried out a specific check of the medication management across the centre;
- looked at care records for 16 patients including physical health assessment plans;
- reviewed capacity assessment documentation and that pertaining to significant decisions;
- looked at training records including three staff records;
- gathered comment cards from 11 service users, relatives and members of staff;
- looked at a range of policies, procedures, audits and other documents relating to the running of the service;

observed five different patient interactions or activities and observed seven patient activities using the short observational framework for inspections.

What people who use the service say

We spoke with eight patients, six relatives, one advocate and received feedback from comment cards. Patients were generally positive about their experience of care and treatment, with most stating staff were kind, polite and helpful. However, two patients did mention that in their apartments it could get loud when some patients were disruptive, with one saying this could make him feel concerned about his safety from other patients.

Patients told us that they wanted more activities, with some saying they often spent most of their time in their room. A relative stated though the family were not provided with an activity timetable they were updated when their relative went out. Some relatives felt there could be more daily activities especially outside the unit. Relatives gave positive feedback about the care given, and were pleased with the improvements they had seen in the patient/relative since being admitted to the hospital.

Some relatives told us staff communicated with them well. Other relatives/carers were concerned that their relative could engage more with activities. Both patients and relatives told us that the hospital was generally clean. Some carers commented that they would have liked to have seen the apartments where their patient

Summary of this inspection

relative stayed but could not due to the hospitals policy on protecting privacy of other patients in the apartment. Comments left on comment cards suggested patients would like greater variety of food and better quality of bed linen and towels.

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?

Good

We rated the safe as good because:

- The service provided a safe environment for the care and treatment of patients in which access was controlled throughout the centre.
- There were sufficient nursing and support staff in place to deliver care appropriately.
- Staff had completed the training requirements to enable them to safely work at the service.
- The service followed a least restrictive approach to managing violence and aggression with staff using de-escalation strategies and when required the use of physical restraint was documented and care plans updated accordingly.
- Staff could identify signs of abuse and knew who to contact regarding safeguarding concerns.
- The service had systems in place for recording and analysing safety concerns.
- There were processes in place for the management team to review safety.
- The service had systems and processes in place for logging incidents.
- Number of Incidents between patients was low due to early staff intervention.
- Staff were debriefed after safety incidents and complaints.
- Managers were proactive in discussing findings from outside the organisation.
- Most staff were up to date with their mandatory training requirements.

However:

- Not all medication was appropriately labelled.
- Systems for recording and sharing lessons learned from investigations were limited.
- The communal bathroom had a non-anti ligature compliant shower which the service mitigated against by only allowing unsupervised access to patients who were well enough. All other patients were supervised if they required access and it was locked when not in use.
- Domestic and clerical staff working only in communal areas were not provided with portable alarms.

Summary of this inspection

- Though processes existed for daily cleaning across patient areas, outside these designated times cleaning did not appear to be done and there were no processes in place to ensure patient areas were deep cleaned when required
- The threshold for escalating safeguarding concerns and the processes for reviewing allegations were not clearly understood and fully demonstrated by the service manager.

Are services effective?

Good

We rated effective as good because:

- Care and treatment of patients involved a multidisciplinary team approach with the service having good links with other agencies and organisations.
- Care plans and assessments looked at strategies for positive behavioural support. They were personalised, relevant, regularly used and up to date.
- Patients had access to a variety of therapies, interventions, assessments and support.
- There was a provision of activities made available for patients including individualised activities.
- There was a focus on identifying and following best practice in autism care.
- There were systems in place to ensure all employees had to complete an induction after their details had been checked and verified.
- Staff handovers were detailed and covered each patient.
- Staff showed good understanding of the Mental Health Act and capacity, with good systems and processes in place to support the service with these and detailed records kept for each patient.
- Information about individual rights was developed in a way that could be understood by patients.
- The service demonstrated good compliance of the Mental Capacity Act.

However:

- The style in which care plans were written was inconsistent and did not always use patient friendly terminology.
- Team meetings and reflective practice sessions were infrequent with staff meetings held every two months and nursing meetings not a regular occurrence with minutes not available for any of these.

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- Patients and carers felt the service offered a supported, kind and caring approach.
- Staff demonstrated detailed knowledge about the patients in their care and showed a genuine concern about patient under their care.
- Staff interactions were mostly positive and person centred in accordance to care preferences documented in the care plans.
- Activities were not rushed and were based around the patient and their individual needs.
- Collaboration and partnership working formed a central part of the services care pathway.
- Patients had access to support from an advocacy service.
- Patient choice was respected, understood and facilitated, which was seen in care plans which documented patient wishes.

Are services responsive?

Good

We rated responsive as good because:

- There were systems and processes in place for triaging and assessing patients before admission to ensure the service could best facilitate their care and treatment.
- Personalisation of bedrooms was encouraged and strategies were in place to develop this with each patient.
- Activities for patients were personalised depending on their rehabilitation needs and interests.
- Information for patients was available in a number of formats.
- Patients had their communication needs assessed and communication plans were developed how best to communicate with each patient which staff understood.
- Individual patient preferences were documented and the service attempted to facilitate these.

However:

- Discharge planning and care plans were not always target and timeline focused to achieve intended goals.

Are services well-led?

Good

We rated well-led as good because:

- The executive team had oversight of the running of the service.
- There were clear processes to review key areas and themes to ensure the management team had oversight.
- There was a clear commitment towards continual improvement and innovation.
- The service was responsive to feedback from patients, staff and external agencies.

Summary of this inspection

- Shortcomings in the recruitment and induction process had been identified and new systems introduced to improve this.
- The service had been proactive in capturing and responding to patients concerns and complaints. There were creative attempts to involve patients in all aspects of the service.

However:

- Learning from incidents and sharing of this was not clearly defined.
- Team meetings were not regular and varied in their format and detail.

Detailed findings from this inspection

Mental Health Act responsibilities

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

We found the service adhered to the Mental Health Act and Mental Health Act Code of Practice.

There had been two MHA monitoring visits to the service since our last inspection, on April 2016 and November 2017.

In April 2016, the following areas of concern were identified:

- Staff consistency to ensure patients could build appropriate therapeutic relationships
- Inconsistencies in the way care plans were written
- A patient was receiving treatment which was not documented on the appropriate legal documentation.

In November 2017, it was found that the provider had partly addressed these concerns in terms of ensuring staff consistency. However, concerns regarding care plans and complete details of treatments were not captured on the appropriate legal documentation, remained. We had identified the following concerns:

- Posters about the Independent Mental Health Act advocacy service did not include contact details for the advocate and the information was not presented in a way that would be understood by most of the patients.
- Very little information for patients was on display.
- Patients did not have access to WIFI and were not allowed mobile phones which had access to the internet or had a camera.
- In managing risk to some patient's other patients were inadvertently disadvantaged including in not being allowed to make their own warm drinks.
- No privacy curtain in the bathroom to allow for discrete observation of patients who could bath independently.
- Care plans varied in quality and easy read versions were full of complex and clinical language.
- Where patients lacked capacity the assessment did not follow the code and the rationale for believing the patient lacked capacity was not recorded.
- Not all prescribed medication was outlined on the legal authority documentation for a patient.

Following the visit in November 2017, the provider submitted plans that showed it would address all these issues by March 2018. During this visit we found that some of these had been addressed, for instance posters did now have contact details for the IMHA and easy read versions were stored in each patient file. Training about the Mental Health Act and Deprivation of Liberty safeguards was now mandatory for all staff. However, some care plans including those following the new approach were still noted to be written in a way which would not be easy to read by all.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our visit all the patients were detained under the Mental Health Act. Staff had a good understanding of the principles of the Mental Capacity Act, in particular, concerning the presumption of capacity and its decision-specific application. Staff showed an awareness of the Act and were able to give examples of when best interest assessments were required. Staff knew if they had any queries or needed further clarification they could consult the MHA administrator or members of the multidisciplinary team for further information.

MCA and Deprivation of Liberty Safeguards (DOLS) training was part of the mandatory training programme all staff had to complete and training compliance was above target of 85%.

Good

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Good

Safe and clean environment

During our visit we reviewed the environment across the centre to ensure it was safe, clean, well maintained and appropriate for the patients that were there. We did this by both observing the environment and checking records, also asking patients, carers and staff.

The service provided a safe environment for the care and treatment of patients. The accommodation had clear lines of sight so all areas could be observed by nursing staff. The layout was spacious to meet the needs of the patients. The environment was regularly reviewed to ensure it was safe which included an assessment of ligature risks with risk reduced through use of anti-ligature furnishings. A communal bathroom, did have potential ligature points which was noted on the ligature risk assessment and access to the bathroom was restricted to those who had been risk assessed. All communal patient areas and most bedrooms were sparse with limited furnishings, with the quiet rooms containing one or two items of simple furniture only. Staff complied with infection control principles which the service monitored through monthly audits.

Access was controlled throughout the centre. Access onto each patient area was restricted to those who needed it and any visitors were accompanied by members of staff. Most patients were being observed by at least one member of staff at all times as documented within their care plans. There were call buttons in each bedroom and staff working in clinical areas all carried portable alarms. However, domestic and clerical staff who did not work in the apartments but could come into contact with patients in communal areas were not provided with portable alarms.

We found that the service had systems and process in place for daily cleaning. Most areas appeared generally clean. Staff told us that they cleaned all patient areas twice a day, whilst housekeeping staff cleaned areas away from the patient apartments. This was corroborated by records which showed this was regularly being done and involved various staff across each area. However, some communal areas did appear in need of a clean to deal with spillages and removal of rubbish whilst other areas did show signs of staining. The service had not had a deep clean any of the patient areas. The service said it was rolling out a programme to train all staff and patient champions how to safely and effectively clean in accordance to guidance which would also cover appropriate areas of health and safety. There was a governance group, the master cleaning group, which was responsible for reviewing cleaning across the service.

The hospital complied with the Department of Health gender separation requirements. The service complied with same sex accommodation guidance at the time of the inspection, male and female patients resided in separate apartments.

Clinic rooms were fully stocked. Each apartment had its own clinic room, which was organised into labelled shelves, clean and fully stocked with equipment which was regularly checked to ensure it was safe to use. There were first aid kits present in each and on each floor clinic rooms had access to a defibrillator and oxygen. The service evaluated how accessible these were in an emergency by conducting monthly audits which looked at the time it took

to get emergency equipment to where it needed to be. Cleaning logs and safety check documentation showed regular checks were being completed to ensure equipment and medication were safe to use. However, in two of the clinic rooms we did find medication including a cream, an injection and some tablets which were not labelled. Most of these were intended for use to treat physical health and related symptoms. Once this was raised with the service these were immediately removed.

Safe staffing

As part of the inspection we looked at staffing arrangements at the service to ensure arrangements were appropriate to deliver safe care and treatment. We did this by speaking to staff and patients in addition to reviewing information provided by the service.

There were sufficient nursing staff in place to deliver care appropriately. The service had an established staff base of seven qualified nurses and 73 nursing assistants, with a further three nurses due to start in the coming months. As a minimum requirement there were four staff allocated to each apartment with team leaders working across the service as needed. During the day within the clinical areas there were four nurses present and two at night. Agency and bank staff were regularly utilised by the service to supplement the core staffing numbers to support enhanced patient observations. Agency staff were booked in blocks of three months at a time to ensure familiarity with the service and patient mix. For the three-month period from 1st January 2018 to 31 March 2018 260 shifts, 9% of all shifts, were covered by temporary staff due to sickness, absence or vacancies. Most of these, 233, were covered by agency staff. There were 102 shifts, just over 3% of all shifts, which could not be covered by temporary staff. During this period there had been three vacant posts which were being covered. In such instances team leaders and deputy managers would cover those shifts. For the 12 month period from 1 April 2017 to 31 March 2018 the staff sickness rate was 2.1%.

Activities and leave were not routinely cancelled due to staffing concerns. The use of high number of staff to support enhanced observations meant that, over the past six months activities and leave were not cancelled due to staff not being available. There had been cancellations due to other factors such as vehicle breakdown or change in patient risk.

The service had active plans to address areas of concerns over staffing. The service had started to address concerns over staff turnover and high use of agency staff by making changes to its recruitment processes and policies. Agency staff after completing an initial period working with the service were offered the opportunity to join the staff bank. There was a process for staff to recommend other staff to work at the service, and for those that applied and were successful, a cash incentive was available for both the new starter and the staff who recommended them. The recruitment process for support staff now included an assessment day which included individual and group assessments followed by an interview process for successful candidates. Those who were offered employment then went through an in-depth induction programme which included a two week programme of familiarising new staff with the service. New starters were given an opportunity to shadow more experienced staff and develop their confidence through supervised working. This included an emphasis on greater communication and feedback to staff, with the new process policies and procedures to facilitate this. There were also support structures in place to help new starters who did not meet key milestones.

Staff had completed the training requirements to enable them to safely work at the service. Mandatory training consisted of 12 different training courses which covered a range of different areas including fire safety, first aid, health and safety. Mandatory training compliance for established staff was above the services target of 85% for all courses except Information governance training, which was at 84.5% compliance. Training included creative intervention training in response to untoward situations(CITRUS), which the service used for least restrictive approach to managing violence and aggression. This was accredited by the British Institute of Learning Disabilities (BILD), and designed specifically for people with learning disabilities and autism

Assessing and managing risk to patients and staff

During the visit we looked at how risk was managed at the service. We did this by looking at records the service held whilst talking to staff and patients about their experiences and understanding.

The service followed a least restrictive approach to managing violence and aggression. All nursing and support staff were trained in the creative intervention training in response to untoward situations which focused on using

least restrictive interventions when dealing with aggression. The service also operated a no seclusion and segregation policy across the service which meant they did not have a dedicated seclusion room on site.

The service had processes in place to assess risk. Risk assessments, which started from admission were regularly updated and reviewed by the multidisciplinary team who reviewed each patient on a weekly basis. A number of tools and outcome measures were utilised for assessing risk including the Salford Tool for Assessing Risk (STAR) and the Short-Term Assessment of Risk and Treatability tool (START). The records we reviewed showed risk assessments were detailed and up to date. Risk management documentation was detailed for each patient. However, in one record we noted that past risks for a patient were not documented where the patient had a previous safeguarding prior to admission to the service.

The service had processes in place to manage risk. Patient observations were carried out in accordance to clinical risk as documented in the care plan by the multidisciplinary team.

Families and children could visit their relatives. The service had a family visiting room, where family members who come to visit could meet their relative. For patients where there were no significant risks identified, children could visit the unit and meet their relative likewise.

De-escalation strategies were used by staff. Records showed staff did attempt other less restrictive forms of de-escalation before restraint was used. These included verbal de-escalation, staff members using a change of tone, posture, facial expressions and asking patients if they wanted to go to the quiet room, the garden or the de-stimulation sensory room.

The use of physical restraint was documented and care plans updated accordingly. The service had a designated lead with responsibility for interventions and dedicated staff champions who were all points of contact for staff with concerns and any training needs. For the six month period October 2017 to March 2018, records showed there had been 253 incidents of restraint used which involved 16 different patients. The service encouraged staff not to use face down restraint and there were no documented incidents of face down restraint being used over this period. Most incidents of restraint, 144, were with the patient laying down in the supine position, where the patient is horizontally laid down with the head faced up. For patients who had been restrained, a physical intervention care plan or restraint reduction care plan had been developed. This also outlined any medical issues which would make the use of certain techniques difficult and a documented plan for the physical interventions to be used if required. These were updated after each incident of use of any physical intervention, with staff required to document any issues and any positives that may have been noted. An incident form was also completed for each incident of restraint which the service collated along with information about all incidents at the service. This was reviewed as part of the monthly restraint audit process where the service looked at the total number of incidents by patient, apartment, severity, position of restraint used, and details of any medication which were used. During our visit the service could not provide evidence of individual incidents of restraint being reviewed by senior managers and investigated where needed, with lessons shared with staff. However, though individual care plans and incident records were updated as required, incidents of the use of restraint were only reviewed on a monthly basis as part of the audit process which collectively reviewed all incidents at the service.

Staff could identify signs of abuse and knew who to contact regarding safeguarding concerns. The service had a good working relationship with the local safeguarding authority, who had no safeguarding concerns about the service. There were processes in place for the service to raise concerns with the authority. Staff received appropriate safeguarding training and those we spoke with could identify the signs for concern and knew who to report these to. There were two delegated safeguarding leads, both deputy managers. However, the registered manager was not clear about the threshold for escalating and the processes for reviewing these. This was demonstrated during our inspection when a patient raised some concerns with our team which were escalated to the registered manager who needed to clarify the internal process and threshold for investigating and referring concerns to the local safeguarding authority. This was done after conversations with the management team.

Track record on safety

During the inspection we asked those present about their experiences of safety and reviewed information about safety and incidents that the service held.

Good

Wards for people with learning disabilities or autism

The service had systems in place for recording and analysing safety concerns. Staff completed paper forms which were reviewed and later inputted into an electronic system.

No serious incidents had recently occurred at the service. We reviewed incident reporting records from 1 July 2017 to 31 May 2018 and found of the 2069 incidents reported, the majority were classed as near misses or of minor harm with four incidents which were categorised as moderate harm. Incident records showed that for the same period, 66% of the total incidents were classed as having caused harm to others. Most of these were either verbal aggression or low level physical aggression towards staff.

The service had systems and processes in place for logging incidents. Staff were required to complete a paper incident form as soon as an incident or safety concern occurred. This would then be reviewed by the nurse in charge. Once the nurse in charge had checked the detail this would then be sent to a member of the management team for review and the details captured by on the reporting system. The management team completed a variety of audits to review safety incidents and related information. These were conducted on a quarterly basis and any incident categorised as moderate harm or above would be reported directly to the management team and the clinical lead who would review these immediately.

Reporting incidents and learning from when things go wrong

During the inspection we reviewed information available about incidents that had occurred at the service and asked staff about their understanding of reporting processes.

Staff were confident to report all concerns. Staff had an awareness of how to raise concerns about safety and incidents and this was noted in the records we examined. We reviewed incident records for the period 1 July 2017 to 31 May 2018. Records showed staff raised concerns about a variety of concerns and incidents ranging from property damage to clinical concerns.

Number of incidents between patients was low due to early staff intervention. Our review of incidents found that incidents between patients was low, because staff were present and able to intervene before escalation could occur. As a result, there were a large number of incidents where patients had been aggressive towards staff.

Staff were debriefed after significant safety incidents and complaints. We were told by staff and management that after any incident staff were debriefed at shift handover. We observed this during the inspection where staff briefed colleagues of an individual incident and some related concerns during the handover. This developed into a brief whole team conversation about the potential causes, associated triggers and risks including how to mitigate these.

Managers were proactive in discussing findings from outside the organisation. Following incidents outside the organisation, managers did speak with staff on an individual basis. This included following a fire at a facility elsewhere in the country, when staff were asked about their understanding of how it could have happened.

Systems for sharing learning were limited. During our conversations with staff and our review of the information from the service, we found little evidence of structures to support the sharing of learning from incidents. The service held weekly governance meetings which all staff could attend and individual staff supervision. However, team meetings were infrequent with the whole team staff meetings held every two months and nursing meetings were not a regular occurrence. Minutes for these were not available for our team to review.

Duty of candour

The duty of candour is a legal duty on hospital, community and mental health services to inform and apologise to patients if mistakes have been made in their care that have led to significant harm. The purpose of duty of candour is to help patients receive accurate and truthful information from health providers. A duty of candour policy was in place and all staff we spoke with were aware of the policy. Staff were aware of duty of candour requirements, which emphasises transparency and openness with patients and carers when things go wrong. The duty of candour requires providers to notify the relevant person of a suspected or actual reportable patient incident. There had been no reportable incidents at the Breightmet Centre for Autism.

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

Good

Wards for people with learning disabilities or autism

Good

Assessment of needs and planning of care

We reviewed how patient care was assessed and planned to ensure it met the needs of individual patients.

The service used paper records. Paper records were used to document care and treatment records at the service. These were securely stored to ensure only staff could access them.

Care plans and assessments were relevant, regularly used and up to date. We reviewed care records for 18 patients. All risk assessments and care plans were up to date, appropriately signed and dated.

A number of different assessments were available, which were used to a varied extent. Admission assessments were mostly detailed and captured key information, However, assessment of physical health and capacity varied in the amount of detail recorded and how often they were completed.

The service used recognised tools to support planning and assessment of care. The service utilised recognised tools for assessing risk including the Salford tool for assessing risk (STAR) and the Short-Term Assessment of Risk and Treatability (START). To measure outcomes and the health of individual patients, the health of the nation outcome scales (HONOS) for learning disability services were used.

Care planning considered support to develop positive behaviour. The service had started to utilise a visual discharge planning pathway, which was person centred with a focus on positive behavioural support and collaboration. This allowed staff to capture for each patient, their strengths, likes and dislikes. It was also intended to involve greater collaboration between the service, the patient, their families and other services.

Care and treatment of patients involved a multidisciplinary team. The service also employed an assistant occupational therapist, an occupational therapist, speech and language therapist, assistant psychologist and a doctor. The responsible clinician had left the week before our inspection, with the new responsible clinician due to start in the coming weeks. In the interim locum arrangements were utilised to ensure there was appropriate responsible clinician cover at the service when required. We saw evidence that patients had been reviewed during this time. The service had been attempting to recruit a permanent full time psychologist since March 2018 with a part time locum psychologist employed to support the assistant psychologist in the interim. However, some carers did feel the difficulty of not having a full time psychologist had impacted on patients in terms of not being reviewed as often and the possibility of decisions about interventions being delayed as a result. The service could not confirm the extent of any impact of this when this was raised with them.

Plans looked at all the needs of the patient. All patients had positive behaviour support plans. All documents were person-centred and autism-friendly, and showed each individual patient's specific needs, preferences and behaviours. For example, the health action plan detailed the support needed by an individual and the patient's preference of support worker and doctor. They were goal-oriented. These were intended to involve all specialities within the service, the patient and carers. The communication and physical health needs of patients were documented in separate planning documents. All attempted to reflect patient views. However, the style in which these were written was inconsistent with the complexity of the language and terminology used not always patient friendly.

Care planning was personalised and looked at the patient as an individual. This included communication passports and activity plans for each patient which were individualised to each patient and included their likes and dislikes. Additional patient specific plans were also present. For one patient with a history of violence and aggression a behaviour booklet was present documenting episodes of aggression. This was used for functional analysis to identify triggers and how best staff could respond during certain circumstances. Specific health plans relating to patient health conditions were also present, for those with long term conditions such as epilepsy or asthma.

There was a provision of activities made available for patients including individualised activities. All patients had access to individualised activities planned around individual needs and activities which were planned for all the patients, both of which were noted on an individualised weekly planner. This included activities provided by external organisations which would visit the service. We saw one example of this when a local farm visited with a

variety of animals for the patients to interact with. The patients responded positively to these and those patients who did not come out into the garden to see them had the animals taken to their bedroom windows to view.

Best practice in treatment and care

As part of our inspection of a service we look at if best practice and guidance are followed to ensure care and treatment are delivered in the most effective way.

Patients had access to a variety of therapies, interventions, assessments and support. Patients had access to physical and mental health support and could access services of a GP on request or when needed. Patient care records showed that staff regularly monitored physical health and made referrals to health care services, where required. We saw this first hand during the inspection when the out of hours GP had been called to review a patient after staff raised concern about his physical health. A range of therapeutic interventions were available for patients which included cognitive behaviour therapy and anger management.

Restrictive interventions approach complied with Department of Health guidance on positive care. The service utilised a management of violence and aggression approach, which complied with guidance on positive and proactive care. There was also a reducing restrictive interventions working group in which staff met once a month to discuss interventions and evaluate their effectiveness.

Evidence based practice for risk assessing and care planning were evident. The Salford tool for assessing risk (STAR), and the health of the nation outcome scales (HoNOS) approach had been utilised by staff in the care of patients in the records we reviewed.

The service had an awareness of current guidance. Current guidance from the National Institute for Health and Care Excellence were known by the service and in some cases, were available for staff to access. Guidance on managing patients in crisis, managing challenging behaviour were being followed by the service.

There was a focus on identifying and following best practice in autism care. The service had started the process of following best practice guidance published by the National Autistic Society. There was an intention to work towards becoming an accredited centre. This was currently at the assessment stage of the process.

The service had a willingness to adapt processes to deliver the most effective care it could. The Speech and language therapist had developed a comprehensive strategy which changed their approach across all teams. Adapted assessments to best meet the needs of individual patients and the most understood key phrases staff could use had been captured in a communication profile for each patient. The service also employed an autism advocate who from personal experience was able to advise staff about issues which affected patients and who was involved in conducting audits to improve the effectiveness of the service. These included a sensory awareness audit to help the service and those working within it understand the impact of these and a separate project to review staff understanding of autism.

Prescribing and management of medication was in accordance to best practice. Our review of prescribing found the service had been following good practice for how medication was prescribed and how patients taking certain medicines had their physical health monitored. Processes were in place to ensure medicines were regularly checked to ensure they were safe to use and regular audits were conducted to look at prescribing and the storage of medication. However, following the administration of anti-psychotic and as required, PRN (pro re nata) medication, involvement of the wider multidisciplinary team including any review by the doctor were not always detailed in the care records.

The nutritional and hygiene needs of patients were regularly audited. The service had process in place to audit hygiene, which was done annually. Nutritional care was reviewed on a six monthly basis as part of the food safe audit.

Skilled staff to deliver care

We looked at the specialisms available and the skills of the teams delivering care at the service by reviewing training and qualification records.

Prior to commencing employment, all employees had to complete an induction after their details had been checked and verified. Pre-employment checks were carried out on all staff to ensure they met the legal requirements to do

their roles and were suitably qualified. We reviewed a random sample of personnel files and all these were up to date and all records in order. After these checks had been completed, staff were required to attend a two week induction programme which included mandatory training, shadowing, and supervised working. Following completion of this supervisors, team leaders and managers met to discuss staff strengths and areas for development and a plan would be developed. This had only recently been introduced at the service. The plan was to develop this further with an accompanying buddying and mentoring scheme, which would be rolled out in the coming months.

A variety of disciplines were part of the team. The suitably skilled staff employed by the service who inputted into the care and treatment of patients included those with expertise from psychiatry, psychology, occupational therapy, speech and language therapy, and nursing. Additional expertise such as medical doctors, district nurses and pharmacists was requested when required from outside the service.

Additional or specialist training was available for staff to do. Staff could access social care online course modules which are designed those working in a health and social setting. Training on behavioural analysis was also available for staff. However, whilst all staff completed mandatory training in autism awareness as part of their training, not all staff had the opportunity to attend any additional specialist training or a specialist accredited learning disability course. Following the inspection the provider confirmed that one staff member was currently completing a post graduate certificate in Autism and Asperger's .

Staff had access to regular management supervision and appraisals. Staff told us they had access to regular supervision and appraisals which was verified in the records we saw. Appraisals were up to date for 94.5% of staff and supervisions were up to date for 91.7% of staff, both above the service target of 90%. Staff appraisal and supervision are a means of assessing staff performance to ensure an individuals practice is appropriate and effective and that they have appropriate support available. They are intended to be used to help create and facilitate plans for rectifying any areas for improvement whilst developing an individual's potential and identifying training. However, concern about the frequency of team meetings and reflective practice was expressed to us, and it appeared team meetings were not held regularly and were inconsistent in their format and content. No minutes were kept of past meetings.

Multidisciplinary and inter-agency team work

Planning of care involved the whole team. The service utilised a range of disciplines and expertise to assess individual patients and plan their care. This included the specialty doctor, nurses, support workers, occupational therapists and the psychology team. This included the development of individualised activity plans which occupational therapists did in collaboration with nursing staff.

There was an effective multidisciplinary team approach to delivering care which was based around the rehabilitation needs of the patient. Staff told us, and records demonstrated that there was a collaborative approach with support workers and nurses, working with the multidisciplinary team to develop individualised activity plans. We saw this in the way the speech and language therapist worked with support workers and nurses to develop an approach to best communicate with a patient who did not verbalise. Occupational therapists worked with the team to develop the most effective activity plans which were responsive to the individual's needs. These were based on the individual needs of the patient, personal interest and life skills to encourage greater independence such as sessions about how to clean and cook. Activities were a mix of those done within the centre and those requiring external visits or trips.

Multidisciplinary team meetings were open to all staff. Meetings were held once a week and reviewed the care and treatment of each patient. These were open to all care and clinical staff.

Staff handovers were detailed and covered each patient. During shift handover staff discussed each patient irrespective of any change, both their presentation during the shift and any key information from the day before. These were an effective opportunity for all staff to input and engage in.

Links with other agencies and organisations were good. The service maintained regular contact with commissioners, care-co-ordinators and home care teams

who were invited to attend meetings to discuss each patient including Care and Treatment Reviews. The service also had a good relationship with the local safeguarding authority.

Adherence to the MHA and the MHA Code of Practice

Good understanding of the Mental Health Act was evident. The service was found to be adhering to the Mental Health Act with staff having a good understanding of the code of practice and knew where to seek further information. This was reinforced by the annual mandatory training staff received about the Mental Health Act, which was above the service target for the number of staff receiving this training.

There were good systems and processes in place to deal with Mental Health Act processes. A member of staff who showed good understanding and knowledge of the MHA oversaw all Mental Health Act related processes. There was no evidence of any practice of blanket restricting the rights of patients, with the last instance of long term segregation a number of years ago. There were clear and effective processes and systems in place to manage MHA related work. However, renewal forms relating section 61 and section 132 did not always base the date of renewal on the date of the initial section.

Detailed Mental Health Act records were kept. The service maintained detailed records relating to the MHA and the detention details of all current patients. There were also processes in place to alert the service when key dates were approaching and offer assurance their responsibilities under the Mental Health Act were being fulfilled.

There were good links with the Independent Mental Health Act Advocate. The service had a good working relationship with the independent advocacy service, with the advocate invited to all Care Programme Approach meetings and hearings. However, the advocate was not always informed about new patients in a timely manner.

Information about individual rights was developed around in a way that could be understood. Patients had their rights explained to them in a manner which was understandable. This included the development and production of an in house easy to ready rights leaflet and picture book for patients.

However, the service infrastructure at the time of our visit did not have wireless provision across the centre.

Good practice in applying the MCA

All staff had an awareness of capacity and related issues affecting patients. Staff demonstrated a good awareness of the Mental Health Act, under which all patients were detained.

Staff knew about the principles of the Act including the presumption of capacity.

Staff received appropriate training. Mandatory training modules on the Mental Capacity Act and Mental Health Act taught staff about their responsibilities and about Deprivation of Liberty Safeguards. The compliance for both was above the services training target with over 94% of staff completing their MCA training.

Systems and process were in place to guide staff. There was an up to date policy in place, which staff were aware of and they knew who to contact for clarification and advice. Systems were in place for capacity assessments and best interest decisions.

The service demonstrated good compliance of the MCA . Capacity was looked at on an individual basis. Those patients who had impaired capacity, their capacity to consent was regularly assessed. Consent to Treatment documentation we reviewed showed patient consent was documented and appropriate forms completed where required, monitored and reviewed. Patients were supported in their care and treatment where they lacked capacity by having best interest meetings held for them which recognised the individuals rights, choices and preferences. There was no covert medicating and seclusion at the service.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

During our visit, we observed how staff interacted with patients by using an observation tool and listening to interactions. We also asked patients and carers about their experiences.

Patients and carers both felt supported. Patients and carers spoke of how staff were supportive of them and their needs. Some carers mentioned receiving picture and video recording updates when their relative had been out on a visit or activity.

Staff were polite, caring and kind whilst they showed a genuine concern about patients. Carers had told us that staff were helpful and showed genuine kindness and concern about the welfare of their loved ones which we too observed. During our visit there were a number of instances we observed where staff had faced aggression from different patients. In each instance the staff members responded politely and calmly, enquiring about the patient' welfare.

Staff demonstrated a detailed knowledge of patients and their needs. Staff described patients' triggers and warnings signs, and responded appropriately. Staff gave examples of how they supported patients' rehabilitation, which included, cooking, cleaning and domestic tasks within the hospital, and activities in a community setting.

Interactions were positive and person centred. Most the interactions we witnessed between staff and patients were positive in which patients would engage with staff and individual activities. Staff treated each patient with dignity and respect, knowing their individual preferences, strengths, likes and dislikes. An example of this included a patient who had been feeling unsettled and anxious, who staff realised would benefit from going to the quiet room. Having asked if he wanted to, gestured he did, and was helped away from the noise of the ward environment. In another instance a patient was reluctant to go out into the garden and partake in an activity involving farm animals. The staff tried a number of techniques to encourage the patient to engage in the activity. They were patient and supportive and having tried to encourage him to go outside, they then attempted an alternative approach. They brought the animals to the patients' bedroom window, from where he began to interact with them and engage in the day's activities.

Respect was shown in person and on records. Staff were respectful with patients when with them and in how they were referred to in care records and care plans.

Activities were not rushed and were based around the patient. Our short observational framework for inspections, is a dedicated tool we utilise to observe and evaluate how meaningful interactions between those present are and how engaged patients are. These demonstrated during activities staff attempted to encourage and engage with patients whilst they were respectful of their preferences and pace.

The involvement of people in the care they receive

Collaboration and partnership working formed a central part of the services care pathway. There was a clear collaborative approach being used by the service. The Visual Discharge planning pathway the service had developed encouraged working in partnership with patients, family members, the multidisciplinary team and commissioners. All the tools the service used encouraged collaborative working and were accessible for people with LD and autism.

Patient and carer involvement was evident. Care plans documented patient involvement in their care, from risk assessments to care planning and planning activities and daily routines. Where consented to do so staff invited carers to MDT meetings, care programme approach meetings and care and treatment reviews.

Patients had access to support from an advocacy service. A named advocate from an independent mental health advocacy services was available to support patients when required. The advocate would hold weekly drop in sessions within the apartments and was invited to care planning approach meetings. The advocate would also visit the service on request of the service or a patient. This was demonstrated during our inspection when the service had contacted the advocate to seek support for a patient following contact from an external agency and a visit was arranged.

Patient choice was respected, understood and facilitated. The service took positive steps to understand and facilitate patient choice. From behavioural analysis to understand why patients reacted a certain way to enabling patient choice the service demonstrated the positive steps it had taken. This included helping a patient with his eating and drinking by understanding he preferred to eat and drink sitting on the floor, for which the service purchased a rug for him to use. In another example the service worked with a patient who regularly vandalised his room, to identify the

Good

Wards for people with learning disabilities or autism

cause for this. They discovered he did not like the colour scheme of the room. As a result they refurbished the room to meet his personal preferences which included brightly coloured floor tiles and painted walls.

Care plans included patient's wishes. Advance decisions which are a summary of the patient's wishes were documented in the care plans we reviewed. These were intended to guide staff on how best to respond to the patient, their wishes and what the patient preferred in a variety of situations including during episodes of distress.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

The service offered inpatient support for those with a learning disability or autism. The service had capacity for 19 patients, though functional capacity had been reduced with one bedroom currently utilised for other purposes. At the time of our inspection the service had 18 patients, which included two recent admissions. This was a substantial increase from when we last visited, when the service had five patients. In the previous 12 months the service had five discharges.

The service had a national catchment. The patients at the service were from outside the local authority catchment area. Referrals were accepted from clinical commissioning groups who commissioned services on an individual patient by patient basis. These commissioners maintained regular contact with the service and their respected patients, monitoring their care, treatment and progress.

There were systems and processes in place for triaging and assessing patients before admission. Prior to a patient being accepted on to the unit, they would be triaged and assessed to identify their suitability both in terms of their current risk and presentation but also in relation to the current patient mix.

There were instances where local patient referrals had been refused. In the past six months there had been two instances when locally residing patients could not be admitted due to lack of beds.

Discharge planning was not always target focused. The service had changed its pathways over the last six months, with the aim of increasing focus on discharge planning in a process referred to as visual discharge planning. This aimed to identify and document the individual needs and preferences of each patient in planning care for discharge. The style in which these were written was inconsistent and did not always reflect the patient voice. The visual discharge plans were not always clearly target focused and did not document timelines to achieve intended goals.

The facilities promote recovery, comfort, dignity and confidentiality

Patient bedrooms were respected as their personal space. Staff treated patient bedrooms as a personal place that belonged to each patient and where they could feel safe. Staff waited outside unless called in or unless there was a specific care need.

Within each patient area there were facilities to promote comfort. Each patient bedroom had an ensuite shower and toilet. Each apartment also had a lounge, a quiet room, a dining room and a staff office which contained the drinks provision. Patients on each apartment had access to an enclosed garden which they could freely access during the day.

Patients had access to additional facilities on the main site. Away from their apartments patients could access a library, a kitchen, a laundry room, a sensory stimulation room and a computer room. These were accessible whilst being escorted by a member of staff, due to the nature of the current observation levels of the patients.

Patients could access drinks and snacks. Patients had access to drinks within each patient apartment, which were kept in a fridge in the nursing office. There were also facilities for making warm drinks which patients could make or staff would make for them. Snacks were contained in the cabinets within the Activities of Daily Living Kitchen on the main site, which patients would have to request to go and get.

Patients had access to telephone and internet facilities. The service policy was patients could have their own mobile

phones if their assessment allowed, this was regularly reviewed. All patients had access to the cordless telephone found in the nursing office of each apartment which could be used in their own bedrooms or privately in the quiet rooms. Access to the internet was available in the therapy rooms under staff supervision and this was a timetabled activity some did regularly. However, there were no wireless internet facilities at the service and the plans for this had not progressed since our last inspection.

The personalisation of patient bedrooms was variable. Some of the patient bedrooms were completely personalised with their own furniture, posters and belongings, whilst many had limited personalisation often through patient choice or need. The service engaged with patients to identify how to develop each bedroom based on patient preferences and kept records of both what personalisation had been attempted and what was present in each room. One example of this was a patient, who often get aggressive and damaged his room but after engaging with him about the reasons for this and his likes, it became apparent he disliked the wall colour. The service renovated his room based on his like of comic book superhero, which included large posters of these characters. There was an immediate impact of this with a reduction of aggression and violence from the patient.

Meeting the needs of all people who use the service

We looked at how the service met the needs of its patients, who at the time of the inspection included patients who had experienced mental health difficulties and had a learning disability, Asperger's syndrome or autism.

The service met the needs of patients who experienced physical difficulties. The service provided supportive utensil for those that required it, which included adapted cutlery for those who needed it. Patients who experienced mobility difficulties, were assisted in a number of ways. The communal bathroom complied with current disability requirements and contained a high rising bath. Patients could utilise a lift if they needed it and for the mini bus steps could be used to get into and out of the vehicle. There was also a lift for those residing in patient areas on the first floor to use if they needed to.

Information was available in formats which could be understood. Though the number of posters and leaflets on display were limited, the service did have information available in different formats. This included easy read and pictorial leaflets and booklets. Easy read information about the Mental Health Act was available for patients.

Communication needs were assessed, supported and understood. Through the work of the multidisciplinary team, communication strategies were developed and documented in each patient's care plan. Where needed patients had access to visual aids, pictorial schedules, objects for referring to and picture boards. Staff had an awareness of these and how patients preferred to communicate including what was meant by different phrases.

Staff understanding and communication approaches were audited to ensure patients were supported. Through work done by the audit team and the specialist in autism who had personal experience of living with autism, the service had run a number of projects to review how effectively the service was meeting the needs of patients. This included one project whereby each patient bedroom was evaluated for the sounds and sights patients experienced, to improve their experience and better facilitate their needs. In another project staff received feedback about how spoken sounds would be interpreted by some patients. This included looking at common statements used by staff and their implications. A series of recommendations from this project had been made which the service had been implementing.

Patient preferences were documented and facilitated. Care records we reviewed listed patient preferences. These included a preference to work with female staff and dietary preferences.

Individual needs of patients for support and help were being met. The patients and carers we spoke with felt the service supported individuals in a responsive and positive manner.

Spiritual needs and requirements were facilitated for those needing them. Spiritual and religious requirements of patients were documented within the patient records. The service also had a multi faith room, which patients could utilise.

Listening to and learning from concerns and complaints

Good

Wards for people with learning disabilities or autism

The service had systems and process in place to gather feedback, review complaints and concerns. Information on how to make a complaint was displayed in the main receptions area and could also be found in the information packs carers and patients were given on admission.

Staff had a clear awareness of how patients and carers could complain. Complaints, concerns and feedback would be discussed at handover along with lessons learned from complaints. Over the twelve months prior to our inspection, there had been a total of three complaints made to the service, none of these were upheld after being investigated.

The service was responsive to concerns and reviewed needs for improvement. The service had recognised a concern about one of its processes and after review had instigated a service improvement, which had senior team oversight. This included an instance when staff found that the first aid kits were not appropriately stocked when there was a need to use it. As a result the service had introduced seals on the kits, which were checked each day. When a seal was found to be broken the full kit would be rechecked and restocked.

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

Good

Vision and values

The vision and values were clear and defined the services strategy and approach. The service values were pride, respect, compassion, standards, patients first and always. These underpinned the new framework the service had developed.

Senior staff showed an awareness of and promoted values and vision of the service. Senior staff we spoke with knew the organisation's values. Staff were introduced to these during their induction to the service and these were regularly discussed with staff at appraisals and supervision meetings which were both above the services target of 90%.

Staff knew who senior managers were for the service. The staff we met were clear about who the management team were at the service and what their individual roles and responsibilities were. Staff also knew and had contact with the chief executive for the provider organisation.

Good governance

There were systems to ensure the executive team had oversight of the running of the service. There was a dedicated team who oversaw governance processes at the service. This included conducting regular audits and chairing weekly themed governance meetings with staff. The team included an analyst to ensure information management processes associated with governance oversight were maintained.

Regular audits were conducted by key themes, throughout the year to ensure effective monitoring was maintained. The service had annual cycle of governance audits, with audits conducted on a weekly, monthly, quarterly or annual cycle. However, , the use of restraint was not separately looked at as part of these scheduled processes.

The service retained oversight of staff training and support. The service routinely reviewed mandatory compliance and the frequency of staff supervision and appraisals.

Systems were in place to ensure the executive team had oversight on the running of the service. Key performance indicators were reported to the board on a regular basis. These were based on the feedback from the audits the service ran.

Leadership, morale and staff engagement

Staff felt supported to carry out their role at the service. The staff we spoke with, were positive about their experiences, the team ethos and felt the team worked well together.

Staff felt confident to raise concerns and give feedback. Staff told us they were confident to raise any concerns or give feedback. Staff knew who senior managers from the provider were. Members of the executive team including the chief executive often visited during their shifts which included during the night and at weekends to ensure staff were happy and did not have any concerns.

Staff spoke of their Job satisfaction. The staff we spoke with were very complimentary about their work and the service. Many had talked about how they go the extra mile, which

included working over their scheduled hours to ensure their work was finished. Some staff spoke of how they had turned down other job opportunities to continue to work at the service, because of culture and ethos at the service.

Commitment to quality improvement and innovation

A culture of improvement was evident across the service. From the comprehensive audit programme to the projects run by the autism specialist advisor, the service had a willingness to review, learn and develop. This was shared by those that worked at the service.

The service had a drive to strive towards best practice. The service demonstrated a desire to follow best practice by working towards receiving accredited status from the national autistic society, conducting internal research about the use of communication. The service had increased its links and collaboration with academic institutions so it could offer more student placements.

Outstanding practice and areas for improvement

Outstanding practice

The work done by the audit team and the specialist in autism, the service had run a number of projects to review how effectively the service was meeting the needs of patients and based on these a series of recommendations and plans for change arose. This included a project in which staff heard about how the environment, its surroundings and how common phrases they used were interpreted by someone with first had experience of living with autism.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The service should have systems and processes for recording and sharing lessons learned.
- All appliances should be anti-ligature compliant including those found in communal bathrooms.
- The service should consider issuing all staff working on the premises including those working in communal areas with portable alarms.
- Cleanliness should be maintained across all patient areas, to ensure areas are clean outside the designated cleaning times. The provider should ensure there are deep cleaning processes available whereby the service can ensure the environment is maintained to the highest standards.
- The provider should ensure all patient medication is labelled appropriately.
- The service should ensure there are systems and processes in place for managers to review each incident of physical intervention to ensure restraint is appropriately used and staff and debriefed in a timely manner afterwards.
- The senior team should ensure that the threshold for escalating safeguarding concerns and the processes for reviewing allegations are clearly understood by senior staff.
- The provider should ensure there are regular and structured team meetings.
- The provider should ensure that past risks are identified and documented appropriately.
- The service should ensure the style in which care plans are written is consistent, patient friendly and always reflect the patient voice.
- Staff should clearly document discharge plans including timelines to achieve intended goals.
- The service should ensure that specialist training is made available for all staff to enhance their expertise in learning disabilities and autism.

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.

This section is primarily information for the provider

Enforcement actions

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.