Cygnet 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?	Good
Are services effective?	Good
Are services caring?	Outstanding
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 Cygnet Bostall House as Good because:

- Patients attended monthly 'empowerment meetings' when they could make suggestions and voice ideas. These ideas had led to changes in the menu, activities and new furniture. They also concerned environmental changes and where to go for day trips.
- Staff arranged birthday parties and 'leaving parties' when patients were being discharged from the service. Patients families and carers were invited to attend.
- When a patient did not wish to have psychology sessions, the psychologist still spent time with the patient. They gradually developed an informal relationship. After some time this led to the patient engaging in psychological therapy.
- Staff provided care and treatment to patients in a collaborative manner. Staff supported patients to understand their needs. They involved patients in decisions and sought patients' views on a wide range of topics. All of the staff were clear that patients' needs were the priority over everything else.
- Staff had a strong focus on relationships with patients, on meeting patients' social and emotional needs, and ensuring patients felt safe.
- Families and carers were invited to visit the service before a patient was admitted. In some cases they had two visits before the patient was admitted. This enabled families and carers to see the environment and to meet staff and patients.
- Patients and families and carers feedback were consistently positive. Patients said staff were nice and that their privacy and dignity were respected. Families and carers felt welcomed, comfortable and involved in patients care.
- Staff had a strong focus on relationships with patients, on meeting patients' social and emotional needs, and ensuring patients felt safe.
- Patients received care and treatment which followed best practice. This included psychological therapies and a range of activities.
- Patients and families and carers gave consistently positive feedback. Patients said staff were nice and that their privacy and dignity was respected. Families and carers felt welcomed, comfortable and involved in patients' care.
- Staff knew how to identify any form of abuse and how to safeguard patients. They knew that if they raised concerns about a patient that it would be taken seriously, and action would be taken.
- There was a positive incident reporting culture and there were well developed systems to embed learning from incidents. The governance system for the service was well developed. The manager had sufficient information to identify potential risks to the safety and quality of care provided to patients. Action was then taken to minimise those risks.
- The leadership team was knowledgeable and experienced. They set clear standards of care and had developed a supportive and positive staff culture. There were very low rates of sickness and low rates of staff turnover. There were no vacant posts in the service.

However:

- The introduction of the new electronic care records system meant that information on patients' care and treatment was in a variety of places at the time of the inspection. This meant staff may not be able to locate all of the information they needed.
- Patients did not have access to an alarm to alert staff to their needs.

Summary of findings

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Good

Cygnet Bostall House

Services we looked at

Wards for people with learning disabilities or autism

Summary of this inspection

Background to Cygnet 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.

The service has a registered manager in place and 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

We have inspected this service twice since 2015. The last inspection was in May 2017 when we rated all of the key questions as good and the service as good overall.

Our inspection team

Cygnet Bostall House was inspected by a CQC Inspector, a CQC Assistant Inspector and a specialist advisor, who is a registered learning disabilities nurse.

Why we carried out this inspection

We inspected this 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?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with three patients who were using the service;
- spoke with the registered manager;
- spoke with four other staff members; including a bank registered nurse, a support worker, the activities co-ordinator and a senior support worker
- spoke with an independent advocate;
- Looked at three care and treatment records of patients:
- carried out a specific check of the medication management; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with three patients. Patients said that staff were very nice. All of the patients said that they felt safe in the service and that their privacy and dignity was respected by staff. Patients said the food was nice.

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

Our rating of this service stayed the same. We rated it as good because:

- The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- The introduction of the new electronic care records system meant that information on patients' care and treatment was in a variety of places at the time of the inspection. This meant staff may not be able to locate all of the information they needed.
- Patients did not have access to an alarm to alert staff to their needs.

Summary of this inspection

Are services effective?

Good

Our rating of this service stayed the same. We rated it as good because:

- Staff undertook functional assessments when assessing the needs of patients. They worked with patients and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs, were personalised and holistic.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Are services caring?

Outstanding

Our rating of this service improved. We rated it as outstanding because:

- Patients attended monthly 'empowerment meetings' when they could make suggestions and voice ideas. These ideas had led to changes in the menu, activities and new furniture. They also concerned environmental changes and where to go for day trips.

Summary of this inspection

- Staff arranged birthday parties and 'leaving parties' when patients were being discharged from the service. Patients families and carers were invited to attend.
- When a patient did not wish to have psychology sessions, the psychologist still spent time with the patient. They gradually developed an informal relationship. After some time this led to the patient engaging in psychological therapy.
- Staff provided care and treatment to patients in a collaborative manner. Staff supported patients to understand their needs. They involved patients in decisions and sought patients' views on a wide range of topics. All of the staff were clear that patients' needs were the priority over everything else.
- Staff had a strong focus on relationships with patients, on meeting patients' social and emotional needs, and ensuring patients felt safe.
- Families and carers were invited to visit the service before a patient was admitted. In some cases they had two visits before the patient was admitted. This enabled families and carers to see the environment and to meet staff and patients.
- Patients and families and carers feedback were consistently positive. Patients said staff were nice and that their privacy and dignity were respected. Families and carers felt welcomed, comfortable and involved in patients care.

Are services responsive?

Good

Our rating of this service stayed the same. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay.
- Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Are services well-led?

Good

Our rating of this service stayed the same. We rated it as good because:

Summary of this inspection

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

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.

All registered nurse had undertaken Mental Health Act training. Staff understood their responsibilities concerning the law and could refer to specific policies on the Mental Health Act. The provider also had Mental Health Act staff that nursing staff could receive advice from.

Mental Health Act paperwork was in good order. Patients had T2 (consent) and T3 (second opinion) certificates where required. The consultant psychiatrist recorded a functional assessment of patients' capacity to consent to treatment. Section 17 leave forms were documented appropriately. There was also documentary evidence that patients were regularly informed of their statutory rights under section 132 of the Mental Health Act. A Mental Health Act audit was also undertaken.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had undertaken Mental Capacity Act training. Staff understood the principles of the Mental Capacity Act and ensured patients were involved in decision making. The multidisciplinary team involved patients in their care and treatment decisions.

There had been no recent situations where it had been necessary for staff to undertake a Mental Capacity Act assessment.

There had been no Deprivation of Liberty authorisations in the year before the inspection.

Good

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Good

Safe and clean environment

Safety of the ward layout

The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Environmental audits included a ligature risk assessment. The risks of ligature anchor points, which patients could use to harm themselves, were minimised. Special anti-ligature fixtures, maintenance adaptations and staff monitoring were all used to minimise these risks. Ligature cutters were also available for staff. A health and safety audit had been undertaken by external contractors. Daily environmental checks were undertaken to identify maintenance issues. At the time of the inspection, there were problems with the locks to doors, including patients' bedroom doors. This made it difficult to open some doors. New locks had been ordered and these were fitted three days after the inspection.

Fire equipment was maintained and there was a fire safety book recording people in and out of the building. Staff had undertaken fire training and all patients had a personal emergency evacuation plan.

There were clear lines of sight in communal areas and convex mirrors were installed for staff to view blind spots. Closed-circuit television cameras were also used in communal areas of the service.

Staff carried personal alarms with them to use in emergencies. There were no wall alarms in patients' bedrooms. However, staff continuously assessed patients' potential risks and were proactive in managing them.

Maintenance, cleanliness and infection control

All of the ward areas were clean, well maintained and had good furnishings. The ward was well decorated. Significant maintenance work had taken place in the large rear garden to meet health and safety requirements. During the inspection we observed a patio door had been broken. This was repaired by the end of the day.

Cleaning staff worked seven days a week and the ward was visibly clean. Hand soap dispensers, handwashing signs, sharps bins (for sharp objects) and clinical waste bags were in place. The manager undertook an annual infection control audit and staff understood infection control principles.

Clinic room and equipment

Medical equipment, such as a sphygmomanometer (blood pressure machine) was clean and had been calibrated. This meant the equipment would work correctly. Resuscitation equipment and emergency drugs were available and checked regularly. A defibrillator, used to restart a patient's heart, was also available. However, records for the blood glucose monitoring calibration were not kept with the blood glucose machine. This meant staff would not know each time they used the machine that it had been calibrated. The records were kept in a different place and showed that staff had calibrated the blood glucose machine.

Safe staffing

Nursing staff

There were no vacant posts in the nursing staff team. Seven registered nurses were employed. Three of these were learning disabilities nurses and the remaining four were mental health nurses. There were also 15 support workers employed.

Nursing staff worked 12 hour shifts, one in the day and one at night. There was one registered nurse and three support workers on each shift. In addition, between 9am and 5pm on weekdays there was an activities co-ordinator.

Four registered nurses and five support workers were available as bank staff to cover vacant or additional shifts required in the service. The limited number of bank staff available meant that they knew the service and the patients. In the 12 months before the inspection, the service used bank staff to cover 54 shifts. Agency staff were used to cover two shifts in the previous 12 months. Staffing levels were met on all shifts and there were always enough staff to carry out physical interventions if required.

If a patient required continuous observation by staff an additional staff member would be booked to provide care for them.

In the year before the inspection, the staff sickness rate was very low at 1%. The staff turnover rate was 11%.

The manager reviewed staffing levels every month with the regional director for the provider. The manager could increase staffing levels if required to provide additional support to patients. Staff could contact an on-call manager when the manager was not available and increase staffing levels if required.

All staff, including bank staff, had an induction when they started working in the service.

Medical staff

A consultant psychiatrist worked in the service three days per week. On the other weekdays the consultant could attend the service if required. Outside of normal workday hours a doctor was on-call and available to attend the service if required.

Mandatory training

All staff had completed all types of mandatory training. Nursing staff in the service undertook 18 types of mandatory training. Some of these were general training, such as in health and safety, infection control and the Mental Capacity Act 2005. However, staff mandatory training also included training specific to the patient group, such as positive behavioural support training.

Bank staff also undertook some mandatory training.

Assessing and managing risk to patients and staff

Assessment of patient risk

We looked at three patients' care and treatment records. Staff in the service assessed patients' risk behaviours during the referral process, prior to admission. When patients were admitted to the ward a full risk assessment was completed. An analysis of patients' behaviour was undertaken. The psychologist completed additional evidence-based risk assessments, specific to individual patients' risks. These included the Historical, Clinical, Risk 20 (HCR 20) for assessment of violence risk and the Assessment of Risk and Manageability of Individuals with Developmental and Intellectual Limitations who Offend – Sexually (ARMIDILO-S).

Patients' risk assessments were updated after incidents or changes in the level of potential risk.

Management of patient risk

Every patient had a positive behavioural support plan to guide staff on how to manage situations when the patient's behaviour could challenge staff. Changes to patients' level or type of risk were identified quickly by staff and plans were put in place to manage those risks. The psychologist spent time with staff supporting them to deal with patients' behaviour that challenged. Staff were able to provide examples of how they managed a number of patients risks. These included early identification of patient agitation and supporting a patient to bathe to prevent self neglect.

There were policies for specific areas of risk management such as searching patients, ligature risks and the enhanced observation of patients. Staff followed these policies.

There were very few blanket restrictions in the service. Patients' deodorant sprays, razors and lighters were stored by staff unless patients needed to use them. Patients could keep their mobile phones and use drinks cans and bottles, unless there was a specific risk with an individual patient. The published visiting times were flexible and patients'

visitor could effectively visit at any time. Patients' visitors could also see and go into patients' bedrooms. Blanket restrictions were audited to assess if they remained necessary.

The service had a no smoking policy anywhere in the grounds. Patients could use vapes.

Restrictive interventions

In the six months before the inspection staff had restrained one patient on 12 occasions. None of these involved the patient being restrained in the prone position or rapid tranquilisation being administered. Restraining patients in the prone position and rapid tranquilisation can carry increased risk to patients' physical health.

The service did not use seclusion or long-term segregation.

The service was involved in the provider's wider reducing restrictive intervention programme.

Safeguarding

Staff were trained in safeguarding, knew how to make an alert, and did so when appropriate. Staff were able to identify both adults and children at risk of significant harm and gave examples of types of abuse, for example financial and physical abuse. Staff knew there was a safeguarding lead in the service to provide additional support to them.

There was a specific room available for patients to visit with children.

Staff access to essential information

Staff used a combination of electronic and paper records regarding patient care and treatment. At the time of the inspection, the provider was changing the electronic system for care and treatment records. The information for patients' care and treatment was stored in a number of places and this made it difficult for staff to know where to get all of the information they needed.

Medicines management

Medicines were ordered, stored and administered to patients safely. Staff recorded medicines administered to patients and all medicines were within their expiry dates.

Staff undertook weekly checks on medicines. A medicines audit in early 2019 was undertaken by an external pharmacy. This audit recorded 83% compliance with best medicines practice. An action plan was developed following this audit and all issues had now been addressed. A pharmacist now visited the service weekly and during that visit checked medicines compliance.

Staff in the service were aware of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured patients were only prescribed medicines they required.

Track record on safety

There had been one serious incident in the 12 months before the inspection. This involved a patient who was absent without leave and potential risks during this time.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Staff reported a range of incidents including verbal abuse and medicine errors. There was a strong incident reporting culture. Staff discussed incidents in morning handover meetings as well as monthly team meetings.

The provider sent all staff monthly bulletins via email which included information about incidents at the provider's other services.

Staff received a debrief after incidents. For example, there was a debrief following any incident of restraint of a patient. The patient also had a debrief. Debriefs involved a discussion of how the situation could have been handled better and prevented. The manager also reviewed closed-circuit television footage of the incident to identify any areas of learning. Learning from incidents included recognition that a patient went to their room to spit out medicines after they were administered. Following this, a staff member now remained with the patient for an hour after they had taken their medicines.

Staff understood the duty of candour and there was a duty of candour policy. The manager described the correct process to take when a mistake had been made, including updating the patient or relative on the outcome of the investigation.

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 looked at three patients' care and treatment records. Patients had a comprehensive assessment when they were admitted to the service. This included a full mental health and physical health assessment. Patients' relatives and carers were also involved in the assessment. They provided important information concerning the patients' routines, habits, likes and dislikes. Patients' also had a functional analysis of their behaviour. This is a recognised assessment to understand why patients behave the way they do. This is an important assessment to develop patients' positive behavioural support plan.

Patients' care plans were personalised and recovery focused. They included a positive behavioural support plan, patients' physical health needs and social skills. Some patients had care plans for domestic skills and communication needs. They also had care plans for dental care, blood pressure monitoring and diet. Staff updated patients' care plans when their needs changed.

Best practice in treatment and care

Patients were prescribed medicines in accordance with guidance from the National Institute for Health and Care Excellence. When required, blood test monitoring for these medicines (such as for lithium) was undertaken as recommended.

Patients had individual psychology sessions addressing a wide range of patients' needs and risks. Examples included a fire-setting programme, managing emotions and cognitive distortions.

Patients had a varied activity programme. This included cooking and activities outside of the service, such as football, shopping and going to the cinema.

Patients had access to physical health care specialists and their physical health care needs were managed by a local GP. Patients had an annual physical health assessment and also attended the dentist regularly. Staff also focused on patients' nutrition to ensure they had a healthy, balanced diet. Staff recorded patients' weight daily. However, staff had recorded the wrong scores on the Modified Early Warning Score (MEWS) system of recording patients' physical health observations. There had been no impact to these errors, and the manager had already identified the issue at the time of the inspection. Staff training had been arranged for the day after the inspection.

Various types of nicotine replacement therapy were available for patients and staff actively talked with patients about stopping smoking. A patient had significantly reduced their smoking recently following these discussions.

Staff used the Health of the Nation Outcome Scales for People with Disabilities (HoNoS-LD) and Life Star as outcome measures. This meant staff could assess patients' progress during and after treatment.

Staff in the service undertook a range of clinical audits, including infection control, patients' care records and blanket restrictions.

Skilled staff to deliver care

A forensic psychologist, speech and language therapist and occupational therapist were in the service one or two days each week. Together with the consultant psychiatrist and nursing staff they formed the multidisciplinary team. Other specialists, such as dietitian, would assess patients following a referral.

All of the staff in the service were experienced and qualified for their role. The psychologist provided additional support to nursing staff to enable them to understand and respond to patients' behaviour.

Nursing staff had an induction into the service. During the initial induction, staff were supernumerary and shadowed more experienced staff. The induction for non-registered nursing staff was aligned to care certificate standards. Bank staff also had an induction.

All staff received regular supervision. These focused on staff members' performance and developmental needs. They were well structured and had Red, Amber, Green (RAG) ratings for areas of development. The supervision attendance rate was 100%. All staff who had been working in the service for more than one year had an appraisal. This was also very well structured.

There was a monthly team meeting for staff. Representatives from each professional group attended this meeting.

Good

Wards for people with learning disabilities or autism

The manager addressed poor staff performance promptly and effectively. The used varied styles to address poor performance, including supporting the staff member and using the capability procedure.

Multi-disciplinary and inter-agency team work

Daily 'flash' meetings were held during weekdays so that all members of the multidisciplinary had up to date information concerning patients. Staff also discussed patients formally at a monthly ward round.

Staff reported that the team worked well together and supported each other. For example, all members of the multidisciplinary team were involved in debriefs following incidents.

Nursing staff had effective handovers. These included all relevant information concerning patients.

Staff in the service worked well with professionals from other agencies. They maintained good relationships with the local authority and welcomed visitors from other agencies to the service. The staff team had a good relationship with commissioners.

Adherence to the MHA and the MHA Code of Practice

All registered nurses had undertaken Mental Health Act training. Staff understood their responsibilities concerning the law and could refer to specific policies on the Mental Health Act. The provider also had Mental Health Act staff that nursing staff could receive advice from.

Mental Health Act paperwork was in good order. Patients had T2 (consent) and T3 (second opinion) certificates where required. The consultant psychiatrist recorded a functional assessment of patients' capacity to consent to treatment. Section 17 leave forms were documented appropriately. There was also documentary evidence that patients were regularly informed of their statutory rights under section 132 of the Mental Health Act. A Mental Health Act audit was also undertaken.

Good practice in applying the MCA

All staff had undertaken Mental Capacity Act training. Staff understood the principles of the Mental Capacity Act and ensured patients were involved in decision making. The multidisciplinary team involved patients in their care and treatment decisions.

There had been no recent situations where it had been necessary for staff to undertake a Mental Capacity Act assessment.

There had been no Deprivation of Liberty authorisations in the year before the inspection.

Are wards for people with learning disabilities or autism caring?

Outstanding ☆

Kindness, privacy, dignity, respect, compassion and support

We observed staff speaking with patients kindly and with genuine interest in the patient. They provided emotional and practical support and advice. Staff displayed a great deal of empathy with patients.

Staff provided care and treatment to patients in a collaborative manner. Staff supported patients to understand their needs. They involved patients in decisions and sought patients' views on a wide range of topics. Staff spoke with passion when they discussed patients and how patients progressed. They were proud to involve patients in their own care and celebrated patients' achievements. All of the staff were clear that patients' needs were the priority over anything else.

Patients said that staff were very nice. All of the patients said that they felt safe in the service and that their privacy and dignity was respected by staff.

Staff knew the patients well and understood their personal, social, cultural and religious needs. They ensured these needs were met. Staff had a strong focus on relationships with patients, on meeting patients' social and emotional needs, and ensuring that patients felt safe. When a patient did not wish to have psychology sessions, the psychologist still spent time with the patient. They gradually developed an informal relationship. After some time this led to the patient engaging in psychological therapy.

Staff arranged birthday parties for patients and 'leaving parties' when patients were being discharged from the service. Patients' families and carers were invited to these parties. Several weeks after patients left the service, the manager contacted their families or carers, or their next

placement, to find out how they were. This was also an opportunity to answer any queries about their needs and to find out how the patient was progressing. The manager then shared this information with staff.

All of the staff in the service were clear that they could raise any issues where they felt a patient had been the victim of discrimination or harassment. They were also clear that the manager would act on this information.

Staff were mindful of the need to maintain patients' confidentiality. They spoke to patients privately to discuss sensitive issues. Staff did not disclose any patient information to others without seeking the patient's consent first.

Involvement in care

Involvement of patients

Before admission, patients were invited to visit the ward. They were shown around and introduced to patients and staff. Within the first week of admission patients met members of the multidisciplinary team and were provided with information about the service.

Patients were involved in decisions about the service in a number of ways. During redecoration, patients chose paint colours. One patient, at their request, had painted their own bedroom. Patients attended daily community meetings to plan their day and discuss any particular requests they had. Patients also attended monthly 'empowerment meetings' when they could make suggestions and voice ideas. These ideas had led to changes in the menu, activities and new furniture. They also concerned environmental changes and where to go for day trips. The occupational therapist kept a log of all patients' suggestions and the action staff had taken as a result. Every three months patients could also attend the regional feedback forum operated by the provider. This was a forum for patients to meet and to discuss ideas and make suggestions wider than the service.

Patients were involved in producing their care plans. In some care plans patients' views were clearly recorded.

Patients with specific communication needs had a care plan for this. This ensured that staff knew how to communicate effectively with patients. All patients in the service at the time of the inspection could speak and hear. However, for some patient's basic language was needed to communicate effectively.

The annual patient feedback survey showed patients were very happy with their care and treatment. They had enough information about their needs and treatment and felt happy and safe. Patients said they had choices in their care and activities and that staff were polite.

An advocate came to the service weekly. They provided advocacy for individual patients to express their views.

Involvement of families and carers

Families and carers were invited to visit the service before a patient was admitted. In some cases they had two visits before the patient was admitted. These visits enabled families and carers to see the environment and to meet staff and other patients.

Families and carers could visit the service at any time. They were invited to multidisciplinary meetings and Care Programme Approach meetings.

Families and carers were asked to complete a survey. They said they were made to feel welcome and comfortable. Families and carers said they found it easy to speak with the nurse in charge, had enough information, that the service was clean and that they felt involved in the patient's care. The provider also held a family and carers forum.

Families and carers of patients who had leave from the service had the manager's telephone number should they need it.

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

Good

Access and discharge

Bed management

The service had six patients and was full at the time of the inspection.

Staff reviewed and responded to new referrals within seven days of receiving them. However, as the service was

popular with commissioners, there was a small waiting list for patients to be admitted to the service. Patients were usually admitted from other services, including secure services.

Discharge and transfers of care

The average length of stay of patients in the service was 18 months to two years. In the previous year there were two delayed discharges. However, both of these were due to funding and future placement issues rather than any actions or omissions by the service.

Staff in the service planned the transition for patients of being discharged from the service carefully. Community services were contacted at an early stage of patients' treatment so that they could begin planning for patients' discharge. Staff in the service liaised closely with community learning disabilities teams.

Patients were gradually given more leave away from the ward and transitions were carried out slowly to minimise any disruption to patients' progress.

The facilities promote recovery, comfort, dignity and confidentiality

All patients had their own bedrooms and had keys to their rooms. Patients could decorate their bedrooms if they chose to. Patients had a range of possessions in their bedrooms.

The service had a clinic room, activity room and a visiting room for children visiting. There was also a small garden at the front of the building and a large garden to the rear. There were a number of areas where patients could go without being disturbed by noise.

Patients reported that the quality of the food was good. There was an on-site kitchen and a chef prepared fresh meals. Patients could make drinks and prepare snacks at any time of the day or night.

Patients' engagement with the wider community

With patients' consent, staff actively involved families and carers in patients' care. They ensured that patients' maintained relationships with those that mattered to them. This included inviting families and carers to important meetings regarding patients' care.

Meeting the needs of all people who use the service

The service had a lift and was fully accessible for people needing to use wheelchairs.

A speech and language therapist assisted staff to develop communication care plans for patients, where required. Pictorial care plans were used when these met patients' communication needs. Staff were not trained in British sign language or Makaton. However, the manager described how, due to the waiting list, patients were not admitted as emergencies. If a patient was admitted who used British sign language or Makaton, all staff would receive training before the patient was admitted.

Patients had information on complaints, their detention under the Mental Health Act, and concerning their treatment. Most of these were in an easy-read format, including the patient survey and information concerning patients' medicines.

Patients dietary requirements were met. This included patients requiring vegan, kosher or halal food as well as patients requiring low fat and low salt diets.

Staff supported patients' pastoral needs. Patients attended places of worship outside of the hospital. If patients did not have leave, staff contacted faith leaders and arranged for them to visit the patient in the service.

Listening to and learning from concerns and complaints

The service had received one complaint in the previous 12 months. This complaint had been upheld.

Patients knew how to complain and this was confirmed in the patient survey. Patients' families and carers also knew how to complain, confirmed by their survey.

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

Good

Leadership

The manager and psychologist had both worked in the service for several years. They provided very clear leadership to the staff team. Expected standards of care

were clearly communicated and both were very knowledgeable and experienced. They had an excellent understanding of the service. The consultant psychiatrist had started working in the service recently.

The manager and psychologist were visible and approachable by both patients and staff.

Developmental opportunities were available for staff. A member of staff had recently been seconded to an associate nurse programme. The manager was keen for staff to develop their skills and experience.

Vision and strategy

The leaders and staff in the service were clearly mindful of the provider's values of care, integrity, respect, empowerment and trust. They consistently demonstrated this through the high quality, person-centred care they delivered. Staff were reminded of the provider's values during induction and regularly at team meetings.

Culture

Staff worked very well together. This was reflected by the low sickness rate, low staff turnover rate and absence of vacant posts. Staff respected and valued the roles of different professionals and supported each other, such as in post-incident debriefs. Staff were proud to work at the service and spoke of the positive culture.

Staff were very clear that they could raise any concerns about poor care without fearing any consequences.

The manager dealt effectively with poor performance and staff were encouraged to undertake professional development. The supervision and appraisal process worked very effectively in identifying how staff could progress.

Governance

There was a clear agenda for quality and team meetings which covered important measurements of safety and quality. The twice monthly clinical governance meeting was conducted effectively, and key indicators of safety and quality were monitored for themes and trends.

Complaints, incidents and safeguarding matters were all areas of focus for the service. Learning from incidents was embedded and clinical audits provided both assurance and identified further actions, which were then undertaken. The service worked effectively with other agencies and welcomed their involvement.

Management of risk, issues and performance

The service risk register accurately reflected risks in the service and actions were taken to minimise them.

Information management

The service had sufficient information to be able to identify potential issues concerning the safety and quality of care.

All staff were trained in information governance. Staff knew about patient confidentiality and all patient care and treatment information was stored securely.

Easy read and pictorial information was available to patients, such as Mental Health Act information. The patient survey and patient information on medicines was in an easy read format. However, information regarding medicines was not in an easy read format.

The service made notifications to other agencies, such as the Care Quality Commission, when it was required to.

Engagement

Staff had information about the provider's work via the provider's intranet system. Families and carers were also provided this information if requested or attended the families and carers forum.

Patients, and their families and carers, had formal and informal opportunities to provide feedback about the service.

Patients were involved in making decisions about the service. This included décor and activities they wished to undertake.

The staff survey was positive. Staff felt the provider promoted equality and diversity and career progression. Areas where staff felt improvement was needed concerned pay scales and better lighting at the front of the building.

Learning, continuous improvement and innovation

The service did not belong to a formal quality accreditation scheme. However, it was clear that the leadership team were focused on improving the quality of the service and continuously looked at how the service could improve.

Outstanding practice and areas for improvement

Outstanding practice

- Patients attended monthly 'empowerment meetings' when they could make suggestions and voice ideas. These ideas had led to changes in the menu, activities and new furniture. They also concerned environmental changes and where to go for day trips.
- When a patient did not wish to have psychology sessions, the psychologist still spent time with the patient. They gradually developed an informal relationship. After some time this led to the patient engaging in psychological therapy.
- Staff had a strong focus on relationships with patients, on meeting patients' social and emotional needs, and ensuring that patients felt safe.
- Families and carers were invited to visit the service before a patient was admitted. In some cases they had two visits before the patient was admitted. These visits enabled families and carers to see the environment and to meet staff and patients.
- Staff arranged birthday parties for patients and 'leaving parties' when patients were being discharged from the service. Patients' families and carers were invited to these parties.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that the transition to the new electronic care records system is undertaken without delay so that information on patients' care and treatment is in one place.
- The provider should ensure that patients have access to an alarm to alert staff to their needs.