

Wast Hills House







Quality Report

Wast Hills Lane
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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?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

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

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

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

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

Summary of findings

Overall summary

We rated Wast Hills as good because:

- Staff carried out environmental risk assessments in areas such as health and safety, access to therapy rooms, use of any equipment and infection control and prevention.
- All units carried out comprehensive assessment of needs when patients were admitted. This included a detailed risk assessment and risk management plan that were updated regularly after every incident. These were based on positive behaviour support approach.
- Staff were trained in safeguarding and demonstrated a good understanding of how to identify and report abuse. Staff knew how to recognise and report incidents through the reporting system. Learning from incidents was shared with staff.
- In the records we checked we saw details of regular physical health checks and that staff continued to monitor health. Staff were trained in different areas of physical health such as dysphagia, postural positioning and epilepsy.
- Patients could access psychological therapies as part of their treatment. For example, anxiety management and therapeutic support programme recommended by the National Institute for Health and Care Excellence.
- Staff treated patient with respect and dignity and they were polite, kind and willing to help. Patients and families were happy with the support they received from the staff and felt that they got the help they needed.
- Staff involved patients in their clinical reviews and care planning and encouraged them to involve relatives and friends if they wished. Patients and their families told us that they could access advocacy services when needed.
- All discharges and transfers were discussed in the multi-disciplinary team meeting and were managed in a planned and co-ordinated way.
- Patients told us that the quality of food was good and meal times were flexible. Patients were supported in maintaining contacts with families by use of Skype and other information technologies. Care was personalised to meet individual needs.
- Staff used a variety of communication tools to help individuals communicate their needs. Families and carers told us that they could raise any concerns and complaints freely.
- Staff told us that they knew how to use the whistleblowing process and felt free to raise any concerns. Staff were offered the opportunity to give feedback on services through the annual staff surveys.
- The unit used performance indicators to gauge the performance of the team. The managers put action plans in place where performance did not meet the expected standard.
- Staff were open and transparent when things went wrong. Incidents were discussed with patients, their families and care managers. Staff felt supported by their managers.

However:

- Not all electrical equipment was checked regularly to ensure it continued to be safe to use.
- The unit did not have arrangements with the pharmacist to specifically audit or monitor prescriptions to ensure doses were safe. The Pharmacist had no direct input into clinical care.
- Staff did not record patients' advance decisions. These are decisions made by patients earlier about how they wanted to be treated at some time in future.
- Patients were not actively engaged in meaningful activities that promoted their independent living skills. Not all patients in the Main house had access to the kitchen and laundry room. The activities appeared to focus more on leisure.
- Wast Hills had information on the number of incidents reported, episodes of restraint and safeguarding, which they analysed for trends and themes. They did not share this information with staff or patients so they could know how the unit was performing.

Summary of findings

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Good 

Wast Hills House

Services we looked at

Wards for people with learning disabilities or autism

Summary of this inspection

Background to West Hills House

West Hills House is located in Kings Norton, Birmingham. It is an independent hospital providing specialist support and services for adults on the autistic spectrum with associated complex needs.

The registered provider for West Hills House is Oakview Estates Limited which is part of Danshell Group.

Nominated Individual: Mr Andrew Murray

Registered Manager: Mrs Sharena Record

Regulated activities:

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

West Hills provides assessment and treatment for up to 28 men and women with autism including Asperger's syndrome, who are also living with a learning disability and complex needs. The service can also support people who may be detained under the Mental Health Act and those who present with behaviours perceived as challenging or with difficulties with social engagement.

West Hills Autism Service consists of:

West Hills Main house, which provides support for up to 18 people who are living with autism and associated complex needs.

West Hills Lodge which is a separate four bed service for people who are living with Asperger's syndrome.

West Hills Annexe, which provides intensive therapy, treatment and support for six people who are living with complex autistic conditions.

West Hills House was inspected on 09 June 2014 in response to concerns raised that standards weren't being met. West Hills House met all five standards that were inspected. A Mental Health Act Review visit was carried out on 15 June 2015 and actions from this visit had been addressed.

Our inspection team

Team leader: Raphael Chichera

The team that inspected the service comprised two CQC inspectors and a variety of specialists: one occupational therapist, one expert by experience and one learning disability specialist 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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the Main house, the Annexe and the Lodge and looked at the quality of the ward environments and observed how staff were caring for patients;
- spoke with five patients who were using the service and three of their relatives;
- spoke with the unit manager;
- spoke with 11 staff members; including doctors, nurses, administrators, cleaning staff, chef, speech and language therapist and occupational therapist;
- looked at six care records of patients and 10 treatment cards;
- carried out a specific check of the medication management;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- we also held a focus group with families and other stakeholders before the inspection day.

What people who use the service say

Patients told us that they felt safe. Relatives and patients were happy with the care provided. Patients and relatives were complimentary about their experiences of care and told us that staff were polite, warm and interacted well with them. Relatives and patients were free to express their views and these were taken into account. Patients and relatives told us that staff were very supportive and

included them in their care planning. They were given information that helped them to make choices about their care. Patients told us that they felt staff treated them with respect and dignity and that they were listened to. Patients and families told us that staff were open and transparent when things went wrong. They discussed incidents with them and were given feedback.

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?

We rated safe as good because:

- The unit had separate accommodation for male and female patients.
- Staff checked medical equipment for use in an emergency regularly to ensure it was in good working order when needed.
- Staff carried out environmental risk assessments in areas such as health and safety, access to therapy rooms, use of any equipment and infection control and prevention.
- There were enough staff available so that patients could have regular one-to-one time with their named nurse.
- Each patient had a detailed risk assessment and risk management plan, which identified how staff were to support them. These were based on positive behaviour support approach.
- Staff demonstrated a good understanding of how to identify and report any abuse.
- The medicines were appropriately stored and the temperatures were regularly monitored.
- Staff were able to explain how learning from incidents was shared within the team. Learning from incidents was discussed in staff meetings, reflective practice sessions and handovers.

However:

- Not all electrical equipment was checked regularly to ensure it continued to be safe to use.
- There were potential ligature points on bedroom door handles, taps and showers in the bedrooms ensuite bathrooms.
- The unit did not have arrangements with the pharmacist to specifically audit or monitor prescriptions to ensure doses were safe.

Good



Are services effective?

We rated effective as good because:

- Detailed individualised care plans and risk assessments were in place, regularly reviewed and updated to reflect discussions held within the clinical review meetings.
- In the records we checked we saw details of regular physical health checks and that staff continued to monitor physical health. Staff referred patients to specialist services when physical health concerns were identified and care plans were implemented to ensure that patients' needs were met.

Good



Summary of this inspection

- Patients could access psychological therapies as part of their treatment. For example, anxiety management and therapeutic support programme recommended by the National Institute for Health and Care Excellence.
- Staff carried out a wide range of regular clinical audits to monitor the effectiveness of the service provided. For example, medicines management, care records and infection control.
- There were regular and effective clinical review meetings that involved the relevant members of the multi-disciplinary team.
- The documentation we reviewed in detained patients' files was up to date, stored appropriately and compliant with the Mental Health Act and the Code of Practice.
- Training records showed that staff had received training in the Mental Capacity Act. There were arrangements in place to monitor adherence to the Mental Capacity Act.

However:

- Not all documents such as health action plans, communication passports and person-centred plans were fully completed.
- There was no direct input from the pharmacist into clinical care.

Are services caring?

We rated caring as good because:

- We observed positive interactions between staff and patients.
- Patients were treated with respect and dignity and staff were polite, kind and willing to help.
- Patients and families were happy and thankful about the support they received from the staff and felt they got the help they needed.
- Staff showed a good understanding of the individuals needs and were able to explain how they were supporting complex patients.
- Staff involved patients in their clinical reviews and care planning and encouraged them to involve relatives and friends if they wished.
- Patients and their families told us that they were able to access advocacy services when needed.
- Staff gathered the views of patients through individual patient forum. The responses of individual patient were fed back to staff, to enable them to make changes where needed.

However:

- Staff did not record patients' advance decisions. These are decisions made by patients earlier to refuse a specific type of treatment at some time in future.

Good



Summary of this inspection

Are services responsive?

We rated responsive as good because:

- Patients on leave could access their beds on return from section 17 leave.
- All discharges and transfers were discussed in the multi-disciplinary team meeting and were managed in a planned and co-ordinated way.
- The units had well-equipped clinic rooms and an area to examine patients.
- Patients told us that the quality of food was good and meal times were flexible.
- Patients were supported in maintaining contacts with families by use of Skype and other information technologies.
- Patients had access to hot drinks and snacks anytime of the day.
- Care was personalised to meet individual needs. Staff adapted the environment to specifically meet the needs for patients with complex needs.
- Staff used a variety of communication tools to help individuals communicate their needs.
- Information on how to make a complaint was displayed in the units. Patients could raise concerns with staff anytime. Families and carers told us that they were able to raise any concerns and complaints freely.

However:

- In the main house two patients enjoyed spending most of their time in the occupational therapy kitchen and a particular lounge. Staff did not address this meaning other patients could not access these areas when they wanted to.
- Patients were not actively engaged in routine meaningful and purposeful activities that promoted their independent living skills. The activities appeared to focus more on leisure.
- Wast Hills house could not prepare halal food on site for a patient.

Good



Are services well-led?

We rated well-led as good because:

- Staff knew and agreed with the organisation's values. Staff knew who the most senior managers in the organisation were. These managers had visited the unit.
- Staff told us that they knew how to use the whistle blowing process and felt free to raise any concerns.
- Staff told us that they were supported by their managers.

Good



Summary of this inspection

- Staff were offered the opportunity to give feedback on services and input into service development through the annual staff surveys.
- The unit used key performance indicators and other measures to gauge the performance of the team. Where performance did not meet the expected standard action plans were put in place.
- Staff were open and transparent when things went wrong. Incidents were discussed with patients, their families and care managers.
- Staff told us the board kept them informed about developments through emails and intranet.

However:

- Wast Hills had information on the number of incidents reported, episodes of restraint and safeguarding, which they analysed for trends and themes. They did not share this information with staff or patients so they could know how the unit was performing.
- The unit had not participated in any quality improvement programmes such as accreditation for inpatient learning disability services from the Royal College of Psychiatrists or involved in any research.

Detailed findings from this inspection

Mental Health Act responsibilities

Training records indicated that staff had received training and showed a good understanding of the Mental Health Act and the Code of Practice. There were five patients detained under the 'Act'.

The documentation we reviewed in detained patients' files was up to date, stored appropriately and compliant with the Mental Health Act and the Code of Practice.

Consent to treatment and capacity forms were appropriately completed and attached to the medication charts of detained patients.

Information on the rights of people who were detained was displayed and independent mental health advocacy services were readily available to support people. Staff were aware of how to access and support people to engage with the independent mental health advocacy when needed.

The explanation of rights was routinely conducted and audited regularly. Easy read leaflets were made available to patients in pictorial form. This ensured that patients understood their legal position and rights in respect of the Mental Health Act. Patients we spoke with confirmed that their rights under the Mental Health Act had been explained to them.

Staff knew how to contact the Mental Health Act administrator who was based at the head office for advice when needed. Audits were carried out twice a year to check that the Mental Health Act was being applied correctly.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records showed that staff had received training in the Mental Capacity Act.

Staff demonstrated a fair understanding of Mental Capacity Act and could apply the five statutory principles.

Patients' capacity to consent was assessed and recorded. These were done on a decision – specific basis with regards to significant decisions. There was detailed information on how capacity to consent or refuse treatment had been sought.

Patients were supported to make decisions where appropriate. When patients lacked the capacity, decisions were made in their best interest, recognising the importance of their wishes, feelings, culture and history.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.

Staff were aware of the policy on Mental Capacity Act and Deprivation of Liberty Safeguards and knew the lead person to contact about Mental Capacity Act to get advice.

Deprivation of Liberty Safeguards applications were made when required. Nine patients were on Deprivation of Liberty Safeguards.

There were arrangements in place to monitor adherence to the Mental Capacity Act.

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

- The layout of all units enabled staff to observe most parts of the unit effectively. The units had CCTV cameras in all communal areas.
- The units had anti-ligature windows and bedroom furniture. Some of the door handles were anti-ligature. There were potential ligature points on bedroom door handles, taps and showers in the bedrooms ensuite bathrooms. These were identified in the ligature risk assessment. The hospital had a detailed risk management plan describing how to minimise this risk for each patient. The manager told us any risk of suicide was identified on admission assessment and that they would not admit any patients with a high risk of suicide.
- The Main house was mixed gender. The unit bedrooms were divided into separate male and female areas, with single ensuite bedrooms and access to separate toilet and bathroom facilities. There was a female only lounge in the female area of the unit. The ward had a shared lounge and dining area. The Annexe and the Lodge were male only units.
- The units had well-equipped clinic rooms with all emergency equipment such as automated external defibrillators and oxygen. Staff checked equipment regularly to ensure it was in good working order, so that it could be used in an emergency. Medical devices and emergency medication were also checked regularly.

- The units were clean, with suitable furniture and were well maintained. However, the décor in the Annexe looked old and needed redecoration. Patients and relatives told us that the level of cleanliness was good.
- Staff carried out regular audits of infection control and prevention. Staff practiced good infection control procedures and hand hygiene to protect patients and staff against the risks of infection. Staff carried out environmental risk assessments in areas such as health and safety, access to therapy rooms, use of any equipment and infection control and prevention.
- Portable appliance tests were not carried out regularly and consistently for all equipment used. Some equipment, such as office computers, fridge, radio, fans and microwave, the last service expired in February 2015. The unit's policy showed that the tests should be carried out yearly.
- All staff had personal safety alarms and nurse call systems were fitted throughout the unit this helped to ensure the safety of patients and that of staff.

Safe staffing

- The units had nine qualified nurses and 44 nursing assistants. There were three vacancies for qualified nurses and 10 for nursing assistants.
- The sickness rate in the 12 month period was 10%.
- The staff turnover rate in the 12 month period was 41%.
- There were 687 shifts filled by bank and agency staff in the last three months. The manager told us that most of the shifts covered by agency staff were for patients on high levels of observations.
- There were 17 shifts that had not been filled by bank or agency nurses, as a result of staff sickness or absence in the last three months.
- Wast Hills House used staffing ladder as a tool to review the number and grade of staff required for each unit.

Wards for people with learning disabilities or autism

- The number of staff on the rota for the last three months matched the number of nurses and nursing assistants and we found that this was consistent.
- There was appropriate use of agency and bank nurses to cover sickness, special observations and annual leave. The managers told us that agency and bank staff used were familiar with the units and patients. The agency staff were given a detailed induction and were booked in advance to cover shifts.
- Activities and community leave were not cancelled because there were not enough staff on duty. We looked at the log of community leave and saw that patients accessed the community on a daily basis. Patients in the Lodge had most of their activities based in the community.
- The units had enough staff available so that patients could have regular one-to-one time with their named nurse. There were enough staff to safely carry out physical interventions.
- Staff told us they could access medical input day and night and that out of hours a doctor on call was available and would arrive on site in an emergency.
- Records showed that the average rate for completed staff mandatory training was 92%.
- The unit had policies and procedures for use of observations to manage risk to patients and staff. These were followed by staff and clearly documented in patients' records.
- Training records showed that staff received safeguarding training. They demonstrated a good understanding of how to identify and report any abuse. There was information about awareness and how to report safeguarding concerns displayed around the units. Staff knew the designated lead for safeguarding who was available to provide support and guidance.
- Safeguarding issues were shared with the staff team through staff meetings, handover and emails. Information on safeguarding was readily available to inform patients, relatives and staff on how to report abuse. Patients and their relatives told us that they felt safe on the units.
- The rapid tranquilisation policy was based on the National Institute for Health and Care Excellence guidance. Each patient on rapid tranquilisation had detailed medical and nursing guidelines. This covered circumstances in which it could be given, the physical observations that needed to be carried out and any risks. The use of rapid tranquilisation was rare and audited regularly. However, on one occasion we noted that although the physical observations had been carried out, the 15 minutes observation sheet was not completed consistently.
- There were appropriate arrangements for the management of medicines. We found good links between Wast Hills and the pharmacy. All nurses were trained in medicines management. The nurses checked the medicines stock levels each day to ensure that the correct doses were administered. However, there was no specific monitoring or auditing by the pharmacist to monitor the effectiveness of safe management of medicines. The doctor and the manager told us that they regularly discussed management of medicines with the pharmacist over the phone.
- We reviewed 10 medicine administration records across all units and the recording of administration was complete and correctly recorded as prescribed. The medicines were appropriately stored and the temperatures were regularly monitored. Patients were provided with information about their medicines.
- Staff were aware of and addressed any issues such as falls and pressure ulcers with the input from the occupational therapist and tissue viability nurse.

Assessing and managing risk to patients and staff

- Staff carried out risk assessments when patients were admitted. This took account of previous history, risk, social and health factors. Staff regularly reviewed these.
- Each patient had a detailed risk assessment and risk management plan, which identified how staff were to support them. The unit used strategies for managing patients' behaviours using the positive behaviour support approach.
- The unit did not use seclusion or long term segregation.
- There were 119 episodes of restraint in the last six months. None were recorded as being in the prone position.
- Staff only used restraint after de-escalation had failed. The staff involved and methods of de-escalation used prior to restraint were recorded to indicate that it was only used after all other methods had been unsuccessful. Staff were trained in physical intervention and were aware of the techniques required. Staff completed an incident report following each incident.
- There was information to let informal patients know that they could leave the unit if they wanted to.

Wards for people with learning disabilities or autism

- All visits from children were risk assessed and a separate visiting room in the Main house was made available.

Track record on safety

- In March 2015 a serious incident of medication error occurred. A patient was not given prescribed medication on two occasions. The clinical team reviewed the incident and developed an action plan to address the key issues from the investigation. They recommended changes to ensure that lessons learnt resulted in changes in practice.
- The root cause analysis identified medication management training for nurses, medication competency assessments for nurses and review of medication policy. All medication stocks to be checked on a daily basis from a weekly basis.
- We saw that recommendations made following the root cause analysis had been acted upon. The learning from this incident was shared with all staff in team meetings and reflective practice group.

Reporting incidents and learning from when things go wrong

- There was an effective way of recording incidents, near misses and never events. Staff reported incidents via an electronic incident reporting form. They knew how to recognise and report incidents through the reporting system.
- Staff were open and transparent and explained the outcomes of incidents to patients, their families and commissioners. Any discussions with patients, families and commissioners about incidents were recorded on the incident form. Patients told us that they discussed any changes with staff after an incident.
- There was a clear structure used to review all reported incidents. Incidents sampled during our visit showed that thorough investigations took place, with clear recommendations and action plans for staff and sharing within the team.
- Staff could explain how learning from incidents was shared within the team. Learning from incidents was discussed in staff meetings, reflective practice sessions and handovers.
- Staff were offered debrief and support after serious incidents.

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

Good 

Assessment of needs and planning of care

- We looked at six records across the units and all contained a comprehensive assessment that had been completed when patients were admitted. These covered all aspects of care as part of a holistic assessment. Staff completed detailed individualised care plans that were regularly reviewed and updated to reflect discussions held within the clinical review meetings.
- In the records we checked we saw details of regular physical health checks and that staff continued to monitor physical health. Staff referred patients to specialist services when physical health concerns were identified and care plans were implemented to ensure that patients' needs were met. Staff were trained in different areas of physical health such as dysphasia, postural positioning, tissue viability, epilepsy and oxygen administration.
- Patients had up to date and detailed person-centred plans. They had up to date health action plans, nutritional assessments, communication passports, contingency plans, personalised, holistic and recovery orientated care plans. However, two files had some of the documents that were not fully completed.
- The unit managed care records appropriately using both paper and electronic systems. Records were organised, stored securely and team members could access patients' records when needed.

Best practice in treatment and care

- Ten medicines charts sampled showed that the National Institute for Health and Care Excellence guidance was followed when prescribing medication.
- Patients could access psychological therapies as part of their treatment. For example, anxiety management and therapeutic support programme recommended by the National Institute for Health and Care Excellence.
- The unit maintained close links with a local GP surgery to monitor physical health needs of patients and ensured physical health care plans were kept up to date.

Wards for people with learning disabilities or autism

Annual health checks and regular physical health checks which included dysphagia assessments, epilepsy and nutrition and hydration were taking place where needed. People had access to specialists such as dentists, chiropodist, podiatrist, diabetic team, dietician, and district nurses. All patients had up to date health action plans. The unit had developed strong links with Queen Elizabeth hospital as part of Health Equality Framework. Patients told us that they were supported by their nurses to visit GP and hospital appointments.

- Nurses and dieticians assessed patients for nutrition and hydration needs. Staff completed fluid and food charts and conducted weight checks each week.
- Health of the Nation Outcome Scales learning disabilities and outcome star were used as clinical outcome measures. The occupational therapist used the Model of Human Occupation Screening tool.
- Staff monitored progress regularly in care records and recorded data on progress towards agreed goals in each patient's notes.
- Staff carried out a wide range of regular clinical audits to monitor the effectiveness of the service provided. They conducted a range of audits on a weekly or monthly basis such as physical intervention, records keeping, nutrition and hydration, care programme approach, medicines, care plans and risk assessments. It was used to identify and address changes needed to improve outcomes for patients.

Skilled staff to deliver care

- The team consisted of a doctor, nurses, nursing assistants, speech and language therapist, activity coordinators, psychologist and the occupational therapist. The team had a wide range of learning disabilities disciplines and workers to ensure that patients received the care they needed. However, there was no direct input from the pharmacist to clinical care. Patients and relatives told us that there were able to see a wide range of professionals depending on their needs.
- Staff told us they had undertaken training relevant to their role. Staff were trained in positive behaviour support, nutrition and diet, dysphagia, autism, Makaton, epilepsy, tissue viability and medicines management.
- New staff had a three week period of induction which involved shadowing experienced staff before they were included in staff numbers. During that period they received training that covered the standards of care certificate.

- Staff were appraised and had access to regular team meetings every month. The average rate of staff that had an appraisal in the last 12 months was 88%. The average rate of staff supervision was 76% in the last 12 months.

Multi-disciplinary and inter-agency team work

- We looked at six records of multi-disciplinary team meetings and found that the units had regular involvement of full range of other health professionals such as speech and language therapist, occupational therapist, psychologist and external social workers. The unit had regular and effective clinical review meetings that involved the relevant members of the multi-disciplinary team working with the patient.
- The units had effective handovers. We looked at handover information and found that they included feedback from review meetings, any changes in care plans, patients' physical health, mental state, risks, observations and incidents.
- Wast Hills House had good working relationships with the external organisations. Community nurses and social workers worked in partnership with the unit to gather information about risks, clinical needs and discharge planning. They worked together to review the risk assessments and crisis plans within the care programme approach process and facilitated safe discharge. They had effective partnership working with GP, hospitals, local community facilities, local authorities, and health commissioners.
- Staff told us that they had developed good working relationships with the local GP and district nurses. The GP visited some of the patients on the unit who were unable to go to the surgery. They told us that information sharing and access was easy between internal and external professionals.
- We saw that community nurses, families, patients and external professionals attended patients' care programme approach meetings. Patients and their families told us that other professionals who were involved in their care and treatment attended their meetings.

Adherence to the MHA and the MHA Code of Practice

- Training records indicated that staff had received training and showed a good understanding of the Mental Health Act and the Code of Practice. There were five patients detained under the 'Act'.

Wards for people with learning disabilities or autism

- The documentation we reviewed in detained patients' files was up to date, stored appropriately and compliant with the Mental Health Act and the Code of Practice.
- Consent to treatment and capacity forms were appropriately completed and attached to the medication charts of detained patients.
- Information on the rights of people who were detained was displayed and independent mental health advocacy services were readily available to support people. Staff were aware of how to access and support people to engage with the independent mental health advocacy when needed.
- The explanation of rights was routinely conducted and audited regularly. Easy read leaflets were made available to patients in pictorial form. This ensured that patients understood their legal position and rights in respect of the Mental Health Act. Patients we spoke with confirmed that their rights under the Mental Health Act had been explained to them.
- Staff knew how to contact the Mental Health Act administrator who was based at the head office for advice when needed. Audits were carried out twice a year to check that the Mental Health Act was being applied correctly.

Good practice in applying the MCA

- Training records showed that staff had received training in the Mental Capacity Act.
- Staff demonstrated a fair understanding of Mental Capacity Act and could apply the five statutory principles.
- Patients' capacity to consent was assessed and recorded. These were done on a decision – specific basis with regards to significant decisions. There was detailed information on how capacity to consent or refuse treatment had been sought.
- Patients were supported to make decisions where appropriate. When patients lacked the capacity, decisions were made in their best interest, recognising the importance of their wishes, feelings, culture and history.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- Staff were aware of the policy on Mental Capacity Act and Deprivation of Liberty Safeguards and knew the lead person to contact about Mental Capacity Act to get advice.

- Deprivation of Liberty Safeguards applications were made when required. Nine patients were on Deprivation of Liberty Safeguards.
- There were arrangements in place to monitor adherence to the Mental Capacity Act.

Are wards for people with learning disabilities or autism caring?

Good 

Kindness, dignity, respect and support

- We observed good interactions between staff and patients. Staff spoke to patients in a way that was respectful, clear and simple and showed positive engagement and desire to support patients.
- Patients and families were complimentary about the support they received from the staff and felt staff provided the help they needed. Our observations and discussions with patients and their families confirmed that they had been treated with respect and dignity. Staff were polite, kind and made them felt at home.
- Staff showed that they understood the individual needs of patients and could describe how they supported patients with complex needs. Patients and relatives told us that staff knew the patients well and supported them the way they were pleased with and made them felt comfortable.

The involvement of people in the care they receive

- There were information and leaflets in an easy read format available to be given to patients as a welcome pack to explain and help them understand how the service worked and what to expect. Relatives and patients confirmed that patients were shown around the units on admission and introduced to staff and others. Patients and relatives were given the opportunity to visit the place before an admission was agreed.
- Our observation of practice, review of records and discussions with patients and their relatives confirmed that patients were actively involved in their clinical reviews, care planning and risk assessments and were encouraged to express their views. Patients told us that

Wards for people with learning disabilities or autism

their views were listened to. Staff created different methods to give information at a level that patients could understand. Patients were given copies of their simplified care plans if they wished.

- Staff involved patients in their clinical reviews and care planning and encouraged them to involve relatives and friends if they wished. Family members' views were taken into account and they were happy about the way they were involved in care discussions.
- Staff were aware how to access advocacy services for patients. Families, carers and patients were given easy read leaflets that contained information about advocacy services. Patients and their families told us that they could to access advocacy services when needed.
- Staff gathered the views of patients through individual patient forum. The manager told us that due to difficulties in communication with most of the patients an individual patient forum was used. This helped to make the most of individual communication methods to generate the views of patients with complex needs. The responses of individual patient were fed back to staff, to enable them to make changes where needed.
- After each Care Programme Approach meeting questionnaires were given out to all external attendees, including care managers, commissioners, social workers and family members. The results were analysed to make any necessary changes. The manager told us that they had recently started a family and carer's forum.
- Staff did not record patients' advance decisions. These are decisions made by patients how they would like to be treated. The manager told us that they were going to act on that to ensure that where appropriate this would be recorded.

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

(for example, to feedback?)

Good 

Access and discharge

- The average bed occupancy was 62% over the last six months.
- The average length of stay was 2.7 years over the last 12 months. The unit had reduced its average length of stay

from 3.2 years in 2013. The manager told us that was due to active discharge planning in that they started to engage commissioners in the first 12 weeks of treatment.

- The majority of patients were out of area placements and all patients had received care and treatment reviews within the last 12 months.
- Patients on leave could access their beds on return from section 17 leave.
- Patients were only moved to another unit for clinical reasons. All patients were admitted to the Main house and were moved to the Lodge or Annexe if their needs had changed after a period of assessment and treatment.
- The unit worked closely with the care managers, community nurses, commissioners and local authorities to ensure that patients who had been admitted were helped through their discharge. All discharges and transfers were discussed in the multi-disciplinary team meeting and were managed in a planned or co-ordinated way.
- If a patient required more intensive care that could no longer be safely managed on the unit; the care manager and commissioners would be contacted to find a suitable placement.
- At the time of our inspection West Hills House had six delayed discharges. The reasons for the delays were that a suitable placement was not ready; suitable placements for two patients not identified; placement identified but funding not yet agreed and equipment required for discharge not yet in place.

The facilities promote recovery, comfort, dignity and confidentiality

- The units had rooms where patients could sit quietly, relax and watch TV or engage in therapeutic activities. The Main house had a computer room, three lounges, occupational therapy kitchen and an art room. In the main house two patients enjoyed spending most of their time in the occupational therapy kitchen and a particular lounge. Staff did not address this meaning other patients could not access these areas when they wanted to. Staff told us that they could pose a risk to other patients who tried to use those areas. We were told other patients had to use the kitchen in the Annexe for occupational therapies. There were two lounges, occupational therapy kitchen and a sensory room in the Annexe.

Wards for people with learning disabilities or autism

- The units had well-equipped clinic rooms and an area to examine patients.
- There was a designated room where patients could meet visitors in private away from the patient area.
- Patients could to make phone calls in private. Some patients used Skype and Face Time on iPad to talk to their families.
- The units had access to a large garden area, which included a smoking area which patients had access to throughout the day.
- Patients told us that the quality of food was good and meal times were flexible. They had a choice of menu that included vegetarian option. The food in the Main house and the Annexe was prepared by the chef and served by staff. Patients in the Lodge planned their own menu and would do their cooking and shopping.
- Patients had access to hot drinks and snacks anytime of the day. Patients in the Annexe and Lodge had free access to the kitchen where they could make their own drinks. However, only one patient had access to the kitchen in the Main house. The manager told us that this was assessed on an individual basis and as patients progressed their level of independence was increased according to risk assessment.
- Patients were able to personalise their own bedrooms. One patient had a specific bedroom designed to meet their needs. The walls were padded to reduce any risk of harm and the bed was fitted with a sensor that could alert staff when the patient was having a seizure. The bedroom had all the belongings that the patient required to relax.
- Each patient had an individual bedroom fitted with a solid door and an allocated locked cabinet where valuables could be secured. Some patients had their own bedroom keys.
- There were a range of activities offered to patients in all units. Each patient had an individual structured programme of activities. However, patients in the Main house were not actively engaged in routine meaningful and purposeful activities that promoted their skills such as cooking, making their own hot drinks and laundry. The activities appeared to focus more on leisure. The manager told us that most the patients in the Main house were difficult to motivate and progress could take a long time. They had recently recruited two activity coordinators to ensure that activities were actively promoted.

Meeting the needs of all people who use the service

- The units had assisted bathrooms for patients with mobility issues. The Main house had lifts and evacuation chairs.
- The unit had information leaflets in an easy read and pictorial format. Staff told us that leaflets in other languages could be made available when needed.
- Interpreting services were available when needed to meet the needs of people who did not speak English well enough to communicate when receiving care and treatment. These were obtained from external services.
- Patients and their families were provided with information leaflets which were specific to the service provided. Patients had access to relevant information in an easy read format which was useful to them such as treatment guidelines, conditions, advocacy, patient's rights and how to make complaints.
- Staff used a variety of communication tools to help individuals communicate their needs. These included the use of Makaton, pictures, objects of reference and photographs.
- All units offered and supported patients with the choice of food they wanted to meet their dietary requirements to meet their religious and ethnic needs when required. There was one patient on halal diet and the manager told us that their chef could not prepare halal food in their kitchen. They told us that it required strict standards to properly prepare it and could not be met by the chef. The patient was taken to a halal restaurant three times a week. The other days the patient would have vegetarian option or visited home to have halal meals.
- All patients had a 'person-centred plan' where a summary of the patient's needs were highlighted, such as likes and dislikes, activities, cultural, religious, ethnic and spiritual needs. All of these were discussed with the patient and family where appropriate. Patients told us that staff support them to meet their needs.
- There were contact details for representatives from different faiths. Patients were supported to meet their spiritual needs.

Listening to and learning from concerns and complaints

Wards for people with learning disabilities or autism

- The unit received six formal complaints and 16 compliments in the last 12 months. None of the complaints were upheld and one was still under investigations.
- Information on how to make a complaint was displayed in the units. Patients could raise concerns with staff anytime or in their individual patient forum and this was effective. Families and carers told us that they were able to raise any concerns and complaints freely.
- Patients knew how to raise concerns and make a complaint. Patients told us they felt they would be able to raise concerns should they have one and were confident that staff would listen to them.
- Staff told us they tried to resolve patients' and families' concerns informally at the earliest opportunity. We observed that staff responded appropriately to concerns raised by relatives and carers of patients and received feedback. Staff were aware of the formal complaints process and knew how to support patients and their families when needed. We saw that one of the complaints raised by a family member on medication was assigned to an external independent doctor to investigate.
- Our discussion with staff and records observed showed that any learning from complaints was shared with the staff team through the handovers and staff meetings.

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

Good 

Vision and values

- Staff understood the vision and values of the organisation and agreed with the values. The vision and values of the organisation were displayed in the units.
- Staff spoken with demonstrated a good understanding of their team objectives and how they fit in with the organisation's values and objectives. Staff knew who their senior managers were and told us that these managers visited the units.

Good governance

- The unit had governance processes to manage quality and safety. The manager used these methods to give information to senior management in the organisation to monitor quality and safety of the unit.
- The manager collected data on how the unit was performing on quality and safety consistently. All information collected was analysed to come up with themes and this was measured against set targets. The manager conducted a unit clinical governance meeting each month. The manager also attended the organisation's clinical governance meeting where quality and safety issues were discussed. However, the information that had been analysed for trends and themes was not shared with staff and patients to know how the unit was performing, for example number of incidents reported, episodes of restraint and safeguarding. Where performance did not meet the expected standard action plans were put in place.
- The manager felt they were given the freedom to manage the unit and had administration staff to support the team. They also said that, where they had concerns, they could raise them. Where appropriate the concerns could be placed on the unit's risk register.

Leadership, morale and staff engagement

- There were no grievances being pursued, and there were no allegations of bullying or harassment.
- Staff told us that they were aware of the trust's whistleblowing policy and that they felt free to raise concerns and would be listened to.
- Staff told us that they felt supported by their line manager and were offered the opportunities for clinical and professional development courses.
- Our observations and discussion with staff confirmed that the teams worked well together. Staff and managers told us that morale within the team always change due to complex needs of the patients they worked with. They told us that there could be times when the behaviour of patients would be very challenging and which staff found stressful. The manager told us that they recognised the stress of working in an acute environment. They had arranged additional staff support from the psychologist. They all spoke positively about their role and demonstrated their dedication to providing high quality patient care. They told us that staff supported each other within the team.

Wards for people with learning disabilities or autism

- Staff told us that managers were accessible to staff, had an open culture, invited new ideas on how to improve the service and willing to share ideas. Staff told us that the managers were very approachable and encouraged openness and transparency when things go wrong.
- Staff were open and transparent when things went wrong. Incidents were discussed with patients, their families and care managers. Patients, families and care managers told us that they were informed and given feedback about things that had gone wrong.

- Staff told us the board informed them about developments through emails and intranet and sought their opinion through the annual staff surveys.

Commitment to quality improvement and innovation

- The unit had not participated in any quality improvement programmes such as accreditation for inpatient learning disability services from the Royal College of Psychiatrists or involved in any research.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should check all electrical equipment regularly so it continues to be safe to use.
- The provider should ensure that there is specific auditing by the pharmacist to ensure safe doses were administered and consider direct input from the pharmacist into clinical care.
- The provider should ensure that patients' advance decisions are taken account of and recorded where appropriate.
- The provider should ensure that patients are actively engaged in routine meaningful and purposeful activities that promote their independent living skills.
- The provider should ensure that information analysed for trends and themes is shared with staff and patients so that they know how the unit is performing.