

Sequence Care Limited

Constance House Hospital

Quality Report

8 Colmore Road, Enfield, London, EN3 7AL

Tel: 020 8 836 9650

Website: <http://www.sequencecaregroup.co.uk/>

Date of inspection visit: 4th - 6th August 2015

Date of publication: 13/11/2015

This report describes our judgement of the quality of care at this hospital. 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 hospital

Good



Wards for people with learning disabilities or autism

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

The service had robust systems in place for managing risk, incidents and safeguarding. Positive risk taking was embraced. Staff used positive behaviour support with patients which meant they used physical interventions as a last resort. Medication policy and procedures were safe and complied with National Institute of Clinical Excellence guidance. The service was appropriately staffed and both patients and staff felt safe.

Care and treatment was multidisciplinary team led, person centred, and involved patients. Records were accurate and up to date. Staff received appropriate training, supervision and appraisals. Staff demonstrated a good knowledge of the Mental Health Act and the Mental Capacity Act.

Care was being delivered in a kind, thoughtful and sensitive manner which respected patients' dignity. Staff had a good understanding of the individual needs of patients and were skilled at de-escalating situations using effective listening skills and by responding sensitively to patients when they were distressed. Patients were fully involved in writing their care and discharge plans.

Staff worked with patients and external agencies to plan discharge from the point of admission. The service provided patients with access to a range of activities including occupational therapy support. Staff and patients were aware of the complaints procedures and the service worked to ensure that people's individual needs were met.

Staff demonstrated a good understanding of the organisation's values of person centred care and encouraging independence. We saw the adoption of these values reflected in the attitudes and actions of the staff. Staff felt safe, supported and happy in their roles. Senior management were visible and approachable. There was a wide range of clinical audits in place to monitor quality and safety. Outcome measures were used to ensure effectiveness of treatment. There was a focus on training staff in order for them to be able to provide training to colleagues. The service followed NICE guidance relating to medication and the Winterbourne view recommendations regarding interventions for adults with learning disabilities.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good



- The service was clean and infection control issues were checked and addressed as necessary.
- Staff had a good understanding of reporting processes and safeguarding. Staff had a good understanding of de-escalation techniques, avoiding physical interventions as much as possible.
- Staff and patients had the opportunity to debrief following incidents.
- The service operated safe staffing levels with appropriately trained and qualified staff.
- Activities and section 17 leave were rarely cancelled.
- Risk management procedures were robust and promoted positive risk taking.

Are services effective?

Good



- Staff worked with patients and external agencies to ensure a holistic assessment of needs took place on admission and this was reviewed regularly.
- Strong multi-disciplinary team working was a feature within the service.
- Patient care was person centred and individualised.
- Physical health needs were monitored and documented in health action plans and discussed in the weekly multidisciplinary team meeting.
- Records were up to date, stored appropriately and subject to regular review.
- Staff received training related to the Mental Health Act and Mental Capacity Act to enable them to carry out their roles effectively.
- Staff received appropriate supervision, appraisal and training.

Are services caring?

Good



- We observed care being delivered in a kind, thoughtful and sensitive manner which respected patients' dignity. Staff had a good understanding of the individual needs of patients.
- Staff were skilled at de-escalating situations using effective listening skills and by responding sensitively to patients when they were distressed.
- Patients were fully involved in writing their care and discharge plans.

Summary of findings

- Patients were involved in designing the welcome pack for new residents as well as anti bullying and safeguarding posters and leaflets.

Are services responsive?

Good



- Patients were appropriately placed at the service with one exception and staff worked with patients and external agencies to plan discharge from the point of admission.
- The service provided patients with access to a range of activities including occupational therapy support.
- Staff and patients were aware of the complaints procedures and the service worked to ensure that people's individual needs were met.

Are services well-led?

Good



- Staff demonstrated a good understanding of the organisation's values of person centred care and encouraging independence. We saw the adoption of these values reflected in the attitudes and actions of the staff.
- Staff felt safe, supported and happy in their roles. Senior management were visible and approachable.
- There was a wide range of clinical audits in place to monitor quality and safety. Outcome measures were used to ensure effectiveness of treatment.
- There was a focus on providing 'train the trainer' sessions for staff to enable them to train colleagues.
- The service followed NICE guidance relating to medication and the Winterbourne View recommendations regarding interventions for adults with learning disabilities.

Summary of findings

Our judgements about each of the main services

Service

Wards for
people with
learning
disabilities
or autism

Rating

Good



Why have we given this rating?

Good



Constance House Hospital

Detailed findings

Services we looked at

Wards for people with learning disabilities or autism

Detailed findings

Contents

Detailed findings from this inspection

	Page
Background to Constance House Hospital	6
Our inspection team	6
How we carried out this inspection	6
Our ratings for this hospital	6
Findings by main service	9
Areas for improvement	20

Background to Constance House Hospital

Constance House is an independent hospital situated in Enfield, North London. It provides care and treatment for up to 11 female patients with learning disabilities, along

with autism, mental disorder or challenging behaviours. On the day of the inspection there were ten patients at the service. Seven patients were detained under the Mental Health Act 1983 (MHA).

Our inspection team

The team comprised one inspection manager, two inspectors, one pharmacy inspector, one mental health act reviewer, one specialist nurse adviser and one expert by experience.

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 hospital and asked a range of stakeholders including care managers and funding bodies for their feedback about the service.

During the inspection visit, the inspection team:

- visited the hospital site and looked at the quality of the environment and observed how staff were caring for patients
- spoke with seven patients who were using the service
- spoke with the Registered Manager
- spoke with eleven other staff members including nursing, medical and therapeutic staff.
- attended and observed one lunch and one multi-disciplinary meeting
- looked at seven treatment records of patients.
- carried out a mental health act review (and looked at ten patient MHA records)
- carried out a specific check of the medication management at the hospital

Detailed findings

- looked at a range of policies, procedures and other documents relating to the running of the service.

Our ratings for this hospital

Our ratings for this hospital are:

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

Are services safe?

Our findings

Safe and clean environment

- The hospital comprised two buildings. The main building had eight bedrooms with en-suite facilities situated over three floors. The main building also housed a communal area with a dining space and an area for patients to watch television together. An additional building at the rear of the property housed three large open-plan flats, each with a sleeping area, a small kitchen area and a large living area. There was a garden at the rear of the buildings.
- There were a number of blind spots throughout the service and these were managed through the use of mirrors, observations and having nursing staff present in communal areas at all times.
- There were a number of ligature risks throughout the service. These had been identified by the provider and a risk assessment and action plan were in place. Patient self harm and suicide risk was assessed and managed individually. As this was a rehabilitation service we would not expect it to be completely ligature free.
- There was a nurse call system in all patient bedrooms. All staff carried personal alarms.
- All areas of the hospital were clean and well maintained. There was a cleaning rota in place which was audited regularly and available for all staff to see.
- The self contained flats were spacious with new furniture in place. Patient bedrooms and flats were homely and individualised, with photographs and posters decorating the walls.
- The service had a small clinic room which was clean and tidy. There was no examination couch. Patients were seen either at their local GP surgery or examined in their own bedrooms when appropriate.
- Resuscitation equipment was in place and checked daily. This was audited on a weekly basis. There were no ligature cutters at the service. This was raised with the registered manager who has ordered a pair for the service. There were no patients at risk of suicide at the time of our visit.
- Emergency medication was present, in date, stored appropriately and checked regularly.

- Environmental risk assessments were undertaken regularly and actions to mitigate risk identified.

Safe staffing

- There were ten health care assistants and one qualified nurse allocated to the hospital during the day. This reduced to five recovery facilitators and one qualified nurse at night.. A ward manager and deputy ward manager were also on duty during weekdays. The multi-disciplinary team for the ward included a consultant psychiatrist, two assistant psychologists, an occupational therapist and a speech and language therapist. (The assistant psychologists received supervision from a qualified psychologist who worked within the wider service.) A yoga therapist and art therapist regularly visited the hospital.
- The ward manager told us they were able to adjust staffing levels in order to take into account patient need. Staff work three 13.5 hour shifts a week and told us they found this shift pattern worked well for them.
- The service had a total of forty six substantive staff. There were nine leavers in the previous twelve months. The service had a seven per cent vacancy rate and an eight per cent sickness rate.
- We observed the previous six months worth of rotas. Minimum staffing levels were met with a couple of exceptions. The service covered vacant shifts with regular bank staff and the use of agency nurses was low. This ensured consistency for patients and meant that staff were familiar with the wards.
- Bank or agency staff were used to cover shifts when required. Senior recovery facilitators, team leaders and management were able to check the rota and call agency to request extra staff if required. Bank staff received supervision and for those who had worked with the service for over twelve months, an annual appraisal.
- Staff and patients told us that activities and leave are rarely cancelled due to staff shortages.
- The service operates an out of hours on call system, with a consultant on call. When the consultant is away the service is able to access a consultant from one of their sister services. The registered manager is able to contact senior management including the Chief Executive Officer outside of hours in an emergency.

Are services safe?

- There were two members of staff suspended from duties at the time of our visit due to misconduct.

Assessing and managing risk to patients and staff

- We looked at seven patient records (out of a possible ten). Risk assessments were completed upon admission and updated regularly. They were clear and detailed had been regularly reviewed. Patient records were stored in a paper format, easily accessible to all staff.
- The service promoted positive risk taking within a context of a clear awareness of risk with robust strategies in place designed to protect rather than inhibit patients. We saw one patient doing handstands against the wall of the communal hallway. Staff reminded her of the risks of hurting herself, but did not try to stop her, they stayed close to her to ensure they could help her if she got into difficulty.
- There were no unjustified blanket restrictions in place. Patients had access to their bedrooms throughout the day, dependent on individual risk assessments and whether or not supervision was required. Smoking was allowed outside, at any time of day, although lighters were contraband. There was a lighter attached to the garden wall for patients to use. There was a search policy in place for patients returning from unescorted leave – a search would be conducted only after discussion with the manager if deemed appropriate. Staff told us this rarely happened.
- The front door to the service was kept locked, there was a sign on the door explaining to patients on unescorted leave how to exit. The front door operated as a double airlock, which suggested a high level of security not commensurate with a low secure/rehabilitative service. Staff were unable to give us a rationale for this, stating ‘it had always been this way.’
- Observation policy was clearly established at the service. Staff were aware of the policy and the observation levels and what this meant in practice. One patient was on one-to-one observation at all times and there was clear rationale for this in her care plan and risk assessment. Staff told us observation was the main means of mitigating risks to patients from ligature points although none of the current patient group were assessed as being at risk of suicide.
- Staff displayed knowledge and skill in de-escalation techniques. All patients had a detailed risk management plan and corresponding positive behaviour support plan which included clear identification of risks, triggers, and individualised strategies to help de-escalate each patient. For example, one patient’s plan identified a strategy which involved encouraging her to cover her ears when she became agitated. Staff were able to tell us about this strategy and how they would cover their own ears as a prompt for the patient to cover hers, which helped her feel calmer and in control of her difficult emotions.
- There were 19 reported incidents of restraint at the service relating to four patients between June 2014 and May 2015. The ward manager and staff told us this was always used as a last resort. Staff are trained in PROACT SCIPr UK (Positive Range of Options to Avoid Crisis and use Therapies; Strategies for Crisis Intervention and Prevention). The focus of this programme is to assist individuals to maintain self control, to enable all staff working with people with developmental disabilities and challenging behaviours to engage in proactive methods of positive behaviour support. It is designed to minimise the use of physical intervention and promoted and accredited by the British Institute of Learning Disabilities (BILD).
- There were no recorded incidents of rapid tranquilisation. One patient’s care plan stated that PRN (‘as and when’) medication was not to be used, that de-escalation techniques were to be prioritised and restraint used only as a last resort.
- Incidents of restraint are recorded on Accident and Incident (AIR) forms. After an incident the patient and staff receive a debrief. After an incident or if patients exhibit escalating, challenging or inappropriate behaviour, a START form is completed. This was used to inform the behavioural support plan. START forms are reviewed by the assistant psychologist and changes to risk management strategies and behavioural support techniques are implemented where appropriate and shared with the staff team.
- Seclusion or long term segregation were not being used at Constance House. De-escalation would sometimes take place in the patient’s bedroom however this was

Are services safe?

with the agreement of the patient and they would be free to leave at any time. Patients were supported to socialise or spend time alone or with staff depending on their individual needs and risks.

- All staff had completed safeguarding vulnerable adults training to level 2. Staff knew what constituted a safeguarding issue and how to report concerns and seek advice if necessary. We saw examples of safeguarding referrals being made appropriately. Safeguarding was a standard agenda item at the multidisciplinary team meeting and the monthly team meeting. One care coordinator we spoke to raised a concern that the local authority were not acting swiftly enough in relation to a safeguarding issue concerning a patient who had assaulted other patients. The care coordinator emphasised however that this was an issue with the local authority, not Constance House, and that the service were very responsive and proactive in responding to safeguarding concerns. There were two open safeguarding issues at the time of our visit, which the service were dealing with appropriately.
- As part of this inspection we looked at the medicine administration records for all 10 patients. Appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded.
- Appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and supplies were available to enable patients to have

their medicines when they needed them. We checked the medicines for each of the 10 patients and no medicines were out of stock. Medication was stored securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were confident about recognising and reporting incidents. They would inform the nurse in charge and complete an Accident and Incident (AIR) form. The START form would also be completed if the incident involved aggressive or challenging behaviour and the multidisciplinary team notes would also be updated in line with the incident.
- Staff told us they would receive a debrief from senior staff including members of the multidisciplinary team and the consultant psychiatrist when available. The service had a 'debrief' folder containing guidance for staff responsible for debriefing staff after an incident, including prompts such as 'what happened?' 'what did we learn?' 'what do we need to do next?' One bank staff told us that she would be contacted at home for a debrief after an incident had taken place if she wasn't due back on shift for a while.
- Learning from incidents would be discussed at monthly team meetings, in handovers and in individual supervision sessions. An individual incident summary for each patient would be drawn up each month and discussed in the MDT meeting. However some of the staff we spoke to were not aware of how learning from incidents was shared across the service.



Are services effective?

Our findings

Assessment of needs and planning of care

- The assessment process started before patients were admitted to the service. There was a transition period where staff spent time visiting the patient and working with their care coordinator and present provider to assess needs and risks. Initial care plans and risk assessments were completed by the nurses with input from the multidisciplinary team. Psychological assessments and recommended interventions were detailed and personalised. The service was in the process of changing the risk assessment format to a traffic light system which enabled risk levels to be clearly identifiable and improved consistency of identifying and managing risks.
- Staff told us that on-going physical health needs were monitored as necessary. Physical health needs were documented in health action plans and discussed in the weekly MDT meeting. Two Health Action plans contained details of health checks including weight, diet, exercise, blood pressure, temperature, GP reviews and blood test results. All patients were registered with a local GP.
- Care plans were developed jointly with patients. All patients had either been given or had seen a copy of their care plan. Care plans reflected the individual needs and preferences of the patients. Each patient had completed a 'My Life Story' document which provided staff with a good background and context to the patient's current situation.
- The service operated a paper records system. Each patient had two files, one containing care plans and risk assessments and a second file containing evidence of assessments and interventions as conducted by the multidisciplinary team. The folders were stored securely in a locked office which all staff had appropriate access to.

Best practice in treatment and care

- Where medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, individual when required protocols, (administration guidance to inform staff about when these medicines should and should not be

given) were in place They provided information to enable staff to make decisions as to when to give these medicines to ensure people were given their medicines when they need them and in way that was both safe and consistent. Where prescriptions were above British National Formulary (BNF) guidelines the service sought authorisation from a Second Opinion Authorised Doctor (SOAD).

- The provider undertook monthly audits to check the administration of medicines was being recorded correctly. Records showed any concerns were highlighted and action taken. This meant the provider had systems in place to monitor the quality of medicines management.
- Staff told us it could sometimes be difficult to refer patients to specialist health services particularly in Enfield and Haringey. They recently struggled to access an external assessment for a patient with suspected dysphagia. They have remedied this by securing external supervision for their in-house speech and language therapist which means they can now undertake dysphagia assessments within the service. The service had developed a working relationship with a local dentist which enabled easy and quick access to an appointment for patients if required. The hospital would pay for specialist private health appointments if unable to access in the community. For example they had paid for private dementia assessments as the local memory clinic would not provide this service.
- Staff were trained in positive behaviour support. They followed the '70/20/10' model which recommends 70% of interventions are proactive, 20% active and 10% reactive (meaning chemical or physical restraint which was always used as the last resort). The recovery model adopted by the service emphasised the promotion of independence and embraced positive risk taking in line with the Winterbourne View Interim Report. Two assistant psychologists visited the service one day a week. They were involved in the joint development of coping strategies with patients and interventions such as reward charts, reflecting NICE guidelines for adults with learning disabilities which recommend 'a clear schedule of reinforcement of desired behaviour and the capacity to offer reinforcement promptly.'

Are services effective?

- Staff demonstrated autism awareness. The importance of patient routines were adhered to by staff, for example one patient had a meal time routine which involved a specific snack at a set time each day, staff ensured this was prioritised for the patient.
- Staff used the Health of the Nation Outcome Scale (HoNOS) on admission and throughout a patient's treatment within the service. Individualised outcome measures such as the Behaviour Problems Inventory (BPI) were used to ensure that the work carried out had a purpose and was effective.
- A number of audits were carried out across the service, including care planning, infection control and quality of case recording to ensure that issues which arose could be picked up in clinical governance meetings and that practice could improve.
- Communication passports were developed with input from the assistant psychologists, patients and carers. Examples of communication methods included pictures and Makaton sign language. One patient preferred to communicate with staff via handwritten notes and we observed a number of these, with responses from staff written clearly and kindly.

Skilled staff to deliver care

- All staff told us the multidisciplinary team worked well across the service. It comprised medical, therapeutic and nursing staff. The team was cohesive and spoke highly of colleagues' diverse skills. The multi-disciplinary team for the service included a consultant psychiatrist, two assistant psychologists, an occupational therapist and a speech and language therapist. A yoga therapist and art therapist regularly visited the hospital.
- New staff received a comprehensive induction. Staff told us they found this helpful. It involved being shown around the unit, Control of Substances Hazardous to Health (COSHH) training, meeting patients and reading patient records and hospital policies. New staff undertook the three month Care Certificate programme. All staff said they felt well supported by their colleagues who would help them out for example when completing an Incident or START form for the first time.
- Staff had appropriate access to supervision, training and annual appraisal. The provider's supervision policy

states all staff should receive supervision at least six times per year. 90% of staff had met this minimum, with a number of staff having exceeded it. The registered manager ran 'Clinical Tuesday' meetings which were an opportunity for senior staff to teach colleagues skills around record keeping and care planning and risk assessment among other topics. Staff of all levels also had the opportunity to attend reflective practice and constructive criticism sessions to encourage a culture of healthy challenge and learning from each other.

- Mandatory training included safeguarding of vulnerable adults, health and safety, first aid, physical intervention and fire safety. All staff were up to date on their mandatory training attendance with one or two exceptions. Staff are encouraged to apply for specialist training, a recovery facilitator had applied for the NVQ in health and social care which was supported by the manager. Staff were positive about training opportunities available to them beyond mandatory training.

Multi-disciplinary and inter-agency team work

- The service had a morning and an evening handover, attended primarily by nursing staff as well as available MDT staff. Staff told us this was a good opportunity to share patient risk information across the team, including details of any incidents or restraint carried out, or concerning changes to any patient's behaviour.
- A communication book is used for staff and the manager to share information. Staff reported this worked very well, was kept up to date and checked regularly by all staff.
- The multidisciplinary team worked together with nursing staff to inform the positive behaviour support plans, risk assessment and care plans. Input was also sought by stakeholders including care coordinators, who provided positive feedback to us about the service. The service reported a good working relationship with the local GPs with whom the patients were registered.

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

- Staff receive training on the MHA and MHA Code of Practice as part of their mandatory training. Most staff were able to demonstrate an understanding of the MHA and their responsibilities as a service in terms of

Are services effective?

ensuring compliance, although some staff were not fully clear on their responsibilities under the MHA. The manager recognised that team knowledge of the MHA was improving.

- The service has support from a MHA administrator who is available to respond to any questions from staff regarding the administration of the MHA. The service also had a MHA 'Champion' who attended a nine month training course designed to equip them with a good understanding of the MHA, so they could share their knowledge and learning with staff day to day.
- Ten MHA records were reviewed, these showed patients were given information about the Mental Health Act on admission to the ward and this was repeated at least once every two months.
- Detention paperwork was filled in correctly, up to date and stored appropriately.
- Section 17 leave was authorised on a form that enabled a carbon copy to be given to the patient. Procedures for renewal of detention had been followed and criteria for renewal had been met.
- People who were detained under the Mental Health Act 1983 had their medicines authorised by a second opinion appointed doctor (SOAD) if they had been detained longer than three months.
- We found T3 certificates (confirmation of authorised medication) had been completed on all the files where the patient had been receiving treatment in scope of section 58 of the MHA. Reports to the CQC under section 61 were all up to date.

- We noted that one patient in particular was receiving medication for a physical illness as well as medication for their mental disorder authorised by a T3 certificate. We reviewed generic assessments of capacity and consent. We were unable to find evidence of a specific assessment of mental capacity or reference to the patient's best interests in consideration of treatment for their physical health.
- Three of the four records we reviewed showed evidence of patients' capacity being assessed and their consent to treatment being recorded around the time that treatment began. There were no concerns about consent to treatment.

Good practice in applying the Mental Capacity Act

- Staff had received training relating to the MCA as a part of their mandatory training. Most staff displayed an understanding of the provider policy related to the use of the MCA and the principles of the Act.
- Three patients were subject to Deprivation of Liberty Safeguards (DoLS) which were found to be appropriately authorised and up to date.
- Staff were able to provide us with numerous examples of capacity assessments which had been undertaken with patients relating to specific issues. Capacity assessments were recently undertaken for all patients regarding the sharing of their information. Where patients were found not to have capacity, the MDT discussed the case and made a decision taking the patient's best interests into account.

Are services caring?

Our findings

Kindness, dignity, respect and support

- There was a friendly and relaxed atmosphere in the service, staff were very visible at all times and observed to be spending time with patients undertaking activities or talking with them.
- We observed care being delivered in a kind, thoughtful and sensitive manner which respected patients' dignity. Staff had a good understanding of the individual needs of patients. We saw that staff were skilful at de-escalating situations using effective listening skills and by responding sensitively to patients when they were distressed.
- Staff empowered patients to make decisions about their lives. We observed staff promoting positive risk taking with one patient who wanted to do a handstand against the wall. Staff informed her of the risks and possible consequences to enable the patient to make an informed decision. The patient decided to do the handstand, and staff stood close by to support her so she didn't injure herself.
- The registered manager had a strong rapport with the patients and was very responsive to them, demonstrating a strong understanding of their individual needs and preferences.
- Patients told us they felt safe and liked the staff who worked at the service. Patients said they would always approach the staff if they had any problems or questions, or just for a chat. One patient told us the staff are very polite and always explain clearly what is happening.
- Feedback received from patients, family members and care coordinators regarding the way staff treat patients was overwhelmingly positive.

The involvement of people in the care they receive

- Patients received a welcome pack when they were admitted to the service. Staff and other patients would

help orientate new patients to the hospital. One patient helped to design the welcome pack, which included information leaflets, as well as illustrations and a welcome letter written by the patient.

- Care plans demonstrated patient involvement, with clear evidence of the patient voice regarding their likes and dislikes and how they wished to be supported. All patients had a copy of or had seen their care plan. Pictorial care plans were used where appropriate and these had a section for the patient's view to be recorded.
- Patients were invited to attend multidisciplinary team reviews so they can share their views and ask questions.
- Families and carers were encouraged to be involved in the care of their relatives. Staff let family and carers know about any patient incidents, decisions around care or appointments so they can be kept involved and invited to comment. Patients' communication assessments included input from families/carers. While there was no formal family/carer support group staff told us they communicate with and support families/carers frequently, although informally. Staff signposted families/carers to support groups run by the local authorities involved in the patients' care.
- The service held a monthly patient community meeting which is an opportunity for patients to raise issues or concerns. This is usually chaired by a patient with support from a staff member. Topics such as friendships and shared living are discussed so any interpersonal issues within the patient group can be discussed and resolved.
- Information regarding an advocacy service was available for all patients and an advocate from MIND would visit the service when requested. Previously a different advocacy service was used and when this changed this was discussed with patients in key work sessions.
- One patient was involved in designing anti-bullying posters and leaflets which were displayed around the service.

Are services responsive?

Our findings

Access and discharge

- The role of the service is to deliver rehabilitative care to patients leaving NHS settings. The admission criteria for the service is patients with learning disabilities, however they will accept a patient with mental health issues but not learning disabilities in exceptional circumstances if it is felt the patient's needs can be best met by the service. There was one patient without a diagnosis of learning disability at the time of our visit.
- There were no exclusion criteria apart from patients with a recent history of deliberate arson.
- The average length of stay was 18 months although this was not always representative of the length of stay expected for some patients, due to the complex nature of their recovery needs. The current group of patients hailed from boroughs in North and East London as well as Oxford and Hertfordshire. Discharge planning included a focus on moving the patient closer to their home borough.
- Discharge planning began at the point of admission and was discussed on a weekly basis at the multidisciplinary team meeting. All patients had discharge plans in place. Some patients were able to tell us about their discharge plans and when they expected to leave the service. There were two discharges in the last six months, including one back to the family home and one to a residential placement, however this broke down. When patients were discharged from the service this always happened during the day and was planned for well in advance.
- Patients always had access to their bed upon return from leave – occupied beds were not allocated for emergencies.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had adequate space for therapies and activities to take place, including a meeting room, the garden 'shed' space which was equipped with a computer, board games, books and craft materials, a communal lounge area and the garden which could be accessed any time during the day or night.

- Families and friends including children were welcome to visit patients at the hospital. Visits could take place in the patients' bedrooms, communal areas or the meeting rooms if preferred. The hospital had a visitors policy in place including special considerations regarding visitors under the age of 18. Children were not allowed in the main ward areas of the hospital, a separate room would be made available for visits to patients by children. To ensure a suitable room would be available, such visits needed to be arranged in advance.
- Some patients had their own mobile phones which they could use freely. Those who did not were able to use the office phone to make a private phone call at any time they required.
- Patients had access to food and drinks 24 hours a day if required. They would be supported in the kitchen in line with their care plan and recovery goals. Patients told us they liked the food and we observed staff offering an alternative choice to a patient who declined the meal on offer on the day of our visit.
- Each patient had an activity plan which detailed the activities they enjoyed and when they liked to do them. Staff and patients told us about the activities available. These included trips out to the local shops, park, café and swimming pool. There was a range of board games, puzzles, and books available. Weekly visits from an art therapist and a yoga therapist took place. The occupational therapist carried out group and individual cooking sessions. Patients also had the option to have a television, radio and games console in their room. The service organised holidays for patients, recent trips included a holiday to Butlins. Patients had considerable amounts of escorted leave to participate in community life on a daily basis.
- Patient bedrooms were personalised with pictures, photographs, and personal belongings.

Meeting the needs of all people who use the service

- Information leaflets including how to complain, contact CQC and access advocacy were available in the service. They were available in English, however, staff knew how to access leaflets and information in different community languages if necessary.
- The service provides food to meet patients' religious needs, for example halal food was provided for a

Are services responsive?

previous patient. Patients were supported to attend faith centres if they wished, one patient had recently started attending church services and was accompanied on these visits by staff.

- The service was accessible to patients with mobility issues, there was a wheelchair accessible side entrance and lift access, and step free access to the garden.

Listening to and learning from concerns and complaints

- Most patients we spoke with told us that they knew how to make complaints. Information about complaints was available on noticeboards and in welcome packs.
- The registered manager told us she did not receive many formal complaints, as patient concerns were addressed informally as soon as they were raised. No complaints were received between Jan –April 2015, two were received in May.
- One patient complained about the content of her care plan and another resident's behaviour towards her. The registered manager met with the patient shortly after the complaint was raised to discuss it in more detail and request further information. A written response was then sent to the patient explaining what action the service would be taking and inviting the patient to discuss the issue further if she was unhappy with the response.
- In one instance, where an issue of patient on patient assault had been raised as a safeguarding incident, it was also treated as a complaint so the manager was able to keep the patient formally updated as to what actions were being taken regarding the incident.
- Staff told us that patients would complain to them individually and in community meetings and minutes of meetings observed demonstrated this was happening. Patients had also complained to family members who had then shared the complaint with the service manager.
- The registered manager told us that informal complaints made by patients would be recorded and forwarded to the director of operations for Sequence Care Group. The director was responsible for reporting details of comments and suggestions to the company's board of directors on a fortnightly basis. This enabled the board to identify any themes arising from comments and suggestions raised across the company's different services.
- We observed a number of compliments received by the service, including from patients, family members and stakeholders. The registered manager had sought feedback from external agencies as part of her appraisal and had received a number of positive comments.

Are services well-led?

Our findings

Vision and values

- Staff had a good understanding of the organisation's values of person centred care, valuing the individual's unique skills and attributes and encouraging independence. We saw the adoption of these values reflected in the attitudes and actions of the staff.
- Most staff were aware of the senior management in the organisation and told us they were visible and approachable, visiting the service often.

Good governance

- The service had effective operating systems in place to monitor quality improvements, including a wide range of clinical audits. Clinical staff were involved in audits undertaken around MHA/MCA understanding and compliance, DoLS, health and safety, infection control, training and supervision, record keeping and physical interventions. The registered manager audited safeguarding, complaints and their responsibilities in terms of sharing required information with CQC on a quarterly basis.
- The service had a system in place for analysing incidents, potential causes and identifying learning. Incidents were discussed in handovers, team meetings and clinical governance meetings. Staff knew how to report incidents. However, some staff told us they were unaware of how learning from incidents was shared.
- The registered manager told us she was given the appropriate time and space to manage the service on a day to day level. Administrative support was sometimes available from the deputy manager and other staff as well as colleagues from the wider organisation, for example the MHA administrator.
- The service was meeting safe staffing levels. The registered manager designed the rota six weeks in advance and was able to increase or decrease staffing levels in line with patient need. Staff were given protected time to complete paperwork so patient contact time could be maximised.

Leadership, morale and staff engagement

- All staff told us they felt happy and supported in their roles. Staff said they felt they were treated with dignity and respect by management and colleagues, and felt they were valued and listened to.
- Some staff told us that they can experience stress sometimes, especially when working with particularly challenging patients, however they felt safe and supported by their team. One staff member told us she had experienced racism from a patient and had been supported appropriately.
- Staff said the service was 'more like a home than a hospital' and felt this culture positively contributed to patient recovery.
- Service management were described as very patient and approachable and staff liked the fact that the registered and deputy manager were very 'hands on', getting involved in day to day work such as cooking, activities and medication.
- Senior management were visible and staff told us they felt senior management were involved in the service and could be contacted for advice or support.
- Staff were aware of the organisation's whistleblowing policy but told us they had not had cause to use it yet.
- There was an emphasis on skilling up staff to deliver training to lower level staff. For example, team leaders have received reflective practice, debriefing and supervision and appraisals training, which they have then delivered to other staff.
- Some staff told us that their wages hadn't increased in over a year and this created a challenge for them, however they felt loyal to the service and recognised the advantages of working for this particular service.

Commitment to quality improvement and innovation

- The service used outcome measures including the HoNOS and BPI in order to measure the effectiveness of their work with patients.
- The service had recently undertaken an internal compliance inspection and developed an action plan in response to the findings.

Are services well-led?

- The service had a 'champions' scheme in place, to ensure each area had a lead who attended specialist training and acted as an expert' in their chosen area. For example champions were allocated for MHA/MCA and health and safety among others.
- The service was piloting a 'positive environment' checklist which focussed on reducing risk triggers within the environment in relation to individual patients.
- The service was in the process of developing 'grab bags' for patients to take with them in the event of an emergency. These contained a selection of patients' clothes and personal belongings as well as important risk and treatment information and medication.

Outstanding practice and areas for improvement

Outstanding practice

- The service promoted positive risk taking within a context of a clear awareness of risk with robust strategies in place designed to protect rather than inhibit patients. We saw one patient doing handstands against the wall of the communal hallway. Staff reminded her of the risks of hurting herself, but did not try to stop her, they stayed close to her to ensure they could help her if she got into difficulty.
- Staff displayed knowledge and skill in de-escalation techniques. All patients had a detailed risk management plan and corresponding positive behaviour support plan which included clear identification of risks, triggers, and individualised strategies to help de-escalate each patient. For example, one patient's plan identified a strategy which involved encouraging her to cover her ears when she became agitated. Staff were able to tell us about this strategy and how they would cover their own ears as a prompt for the patient to cover hers, which helped her feel calmer and in control of her difficult emotions.
- Staff were trained in positive behaviour support. The recovery model adopted by the service emphasised the promotion of independence and embraced positive risk taking in line with the Winterbourne View Interim Report. Two assistant psychologists visited the service one day a week. The service used reward charts, reflecting NICE guidelines for adults with learning disabilities which recommend 'a clear schedule of reinforcement of desired behaviour and the capacity to offer reinforcement promptly.'
- Patients helped to design the welcome pack for new patients, which included information leaflets, as well as illustrations and a welcome letter written by the patient.
- The service was piloting a 'positive environment' checklist which focussed on reducing risk triggers within the environment in relation to individual patients.
- The service was in the process of developing 'grab bags' for patients to take with them in the event of an emergency. These contained personal belongings, clothes, treatment and risk information and medication.

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should ensure systems are in place for sharing learning from incidents
- The provider should ensure ligature cutters are available to all staff if required in the event of an emergency.