Rohan

Quality Report

Mill Lane
Sandwich
Kent
CT13 0JU
Tel: 01304 611371
Website: www.turning-point.co.uk

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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 Rohan as **good** because:

- All patients had risk assessments. Risk information was reviewed regularly and documented. We saw that the reviews of risk were part of the multi-disciplinary care review process. There were appropriate systems embedded with regards to safeguarding vulnerable adults. De-briefing both staff and patients took place after incidents.
- Patients' needs were assessed and care was delivered in line with their individual care plans.
- Records showed that all patients received a physical health assessment and that risks to physical health were identified and managed effectively. Staff followed best practice in treatment and care. Staff received appropriate mandatory and statutory training, supervision and appraisals.
- Therapeutic activities were tailored to the individual patient's needs and likes. Staff respected patients' diversity and human rights. Attempts were made to meet people's individual needs including cultural, language and religious needs.
- Patients we spoke with were positive about the staff. The interactions we observed between patients and staff were friendly and respectful. Feedback received from families was good.

However:

- Staff were not trained in the use of a defibrillator.
- There were not effective systems in place to ensure access to medical cover was available over a 24-hour period at all times.

Summary of findings

Contents

Good

Rohan

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

Summary of this inspection

Background to Rohan

Rohan is registered to provide the regulated activities: treatment of disease disorder or injury; assessment or medical treatment for persons detained under the Mental Health Act 1983; and diagnostic and screening procedures.

Rohan has a registered manager.

Rohan provides a bespoke service for two male patients who have learning disabilities or autism and challenging behaviours. At the time of our inspection, both patients were detained under the Mental Health Act (MHA).

At the time of the inspection, the service had two individual self-contained flats located on the ground floor.

Kent Community Health NHS Trust previously managed Rohan. Turning Point acquired the service on the 9 September 2013. Since then there have been no inspections carried out at this service by the Care Quality Commission (CQC).

Our inspection team

Team leader: Hannah Cohen-Whittle, inspector.

The team that inspected Rohan comprised two CQC inspector's (one was shadowing); CQC's learning disability policy manager with expertise in learning disability and a Mental Health Act Reviewer.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited both self-contained flats at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with one patient who was using the service, and the relatives of one patient;
- spoke with the registered manager;
- spoke with five other staff members; including nurses and support workers;
- spoke with an independent advocate;
- received feedback from care co-ordinators or commissioners;
- looked at two care and treatment records of patients, including prescription charts;
- undertook a Mental Health Act review on both self-contained flats;

Summary of this inspection

- looked at cleaning schedules for all wards;
- reviewed the personnel files of five staff;
- carried out a check of the medication management including prescription charts; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

The patient we spoke with was positive about the staff. The interactions we observed between the two patients and staff were friendly and respectful. Staff responded to patients needs in a calm and respectful manner.

The patient told us they felt safe in their surroundings. They felt well supported by staff who encouraged them to be independent, listened to their needs and treated them with respect.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because:

- Staff received appropriate mandatory training.
- Both patients had up to date risk assessments.
- Risk information was reviewed regularly and documented. We saw that the reviews of risk were part of the multi-disciplinary care review process.
- There were appropriate systems in place with regards to safeguarding vulnerable adults.
- De-briefing staff took place after incidents.

However:

- There was no appropriate medical cover in place for when the doctor was off on annual leave or sickness.
- Staff were not trained in the use of a defibrillator.

Are services effective?

Good

We rated effective as **good** because:

- Patients had a comprehensive assessment in place that was individualised, person-centred and holistic with a focus on recovery.
- Records showed that patients received a physical health assessment and that risks to physical health were identified and managed effectively.
- Staff received appropriate training, supervision and appraisals.
- Staff participated in regular reflective practice sessions where they were able to reflect on their practice and incidents that had occurred.
- Patients capacity to consent to treatment was recorded and assessed on admission and then regularly throughout their stay in hospital. Staff carried out best interest assessments when needed.

However:

- Mental Health Act training was not provided as mandatory training for staff.
- There was limited participation in clinical audits, including the green light toolkit.

Summary of this inspection

Are services caring?

Good

We rated caring as **good** because:

- The patient we spoke with was positive about the staff.
- The interactions we observed between patients and staff were friendly and respectful.
- Feedback received from families was good.
- Staff had a good understanding of the individual needs of patients.
- Staff had good knowledge on how to de-escalate situations and worked as a team to promote a safe environment.

However:

- The service had no formal way of seeking feedback from patients or relatives/carers.

Are services responsive?

Good

We rated responsive as **good** because:

- There was good provision of and access to therapeutic activities.
- Staff respected patients' diversity and human rights.
- Staff received training in equality and diversity as part of their mandatory training.

Are services well-led?

Good

We rated well-led as **good** because:

- Staff told us they felt the senior management team were approachable at all times and felt confident in speaking with them.
- Staff told us they were aware of the whistle-blowing process and were confident they could raise concerns if needed.
- Staff demonstrated that they were motivated and dedicated to deliver the best care and treatment they could for the patients on the wards.
- There was good staff morale and the culture of the service was open and transparent.

However:

- There was a lack of participation in clinical audit.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Turning Point had a contract with Kent and Medway NHS Social Care Partnership Trust to provide support with managing the administration of the Mental Health Act (MHA) 1983. They provided information and guidance for staff when required.

We carried out a specific Mental Health Act Review on both self-contained flats. We found that the use of the MHA was mostly good in the service. However, both patients had been detained for a number of years and not all paperwork was available. Mental Health Act documentation reviewed was found to have some anomalies about dates on historic detention papers. This dated back prior to the provider having taken on the service. We raised this with the registered manager immediately during the inspection so that they could take action to ensure that detention was lawful.

Patients capacity to consent to treatment was recorded and assessed on admission and then regularly throughout. There were copies of consent to treatment forms accompanying the medication charts as required by the MHA code of practice. Medicine for mental disorder may be administered to a patient either with his/her capable consent (T2) or, if s/he withholds consent or is incapable of giving consent (T3) authorisation by a second opinion appointed doctor (SOAD). Both patients had their medication authorised through a form T3 that had been completed several years previously in 2009 and 2010. Although this does not make the forms unlawful best practice would be to renew T2 certificates at 12 monthly intervals for T3 certificates at 24 monthly intervals. We discussed this with the registered manager on the day of the inspection who told us they would raise this with the mutli-disciplinary team.

Patients had their rights under the Mental Health Act explained to them routinely and in an appropriate way that they would understand.

A standardised system of authorising leave was in place. All forms were in date and the parameters were clear. Neither of the patients were offered a copy of the Section 17 leave form due to their levels of comprehension.

Patients had access to an independent Mental Health Act advocate (IMHA).

Mental Capacity Act and Deprivation of Liberty Safeguards

There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy.

Staff we spoke with demonstrated a good understanding and knowledge of the Mental Capacity Act (MCA) and of the hospital policy. Capacity to consent was assessed by staff on admission of a patient and then regularly throughout. One patient required specialist healthcare but lacked capacity to consent. We saw evidence that staff carried out best interest assessments and worked with the patient to prepare and support them.

We saw that staff completed Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) e-learning training. At the time of the inspection, 88% of staff had completed this training.

At the time of our inspection, there were no patients subject to a DoLS authorisation and no applications had been made.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Good

Safe and clean environment

- Both self-contained flats were on the ground floor. Each flat was spacious and comprised of a separate lounge, dining area, bedroom, bathroom and garden. The self-contained flats layout enabled staff to observe most parts of the flats. There were some restricted lines of sight but these were adequately mitigated and reduced through observations of patients at all times.
- The self-contained flats complied with Department of Health guidance on same-sex accommodation. Both patients were male and there was no gender mix.
- Staff completed ligature audits to identify ligature risks in the self-contained flats. This identified and rated risks and made recommendations for their removal or management. During the inspection, we undertook a detailed tour of the flats and spoke with staff about how they were mitigating the risks identified. Staff told us that because both patients were on enhanced eyesight observations at all times with several members of staff at no point were they left unsupervised.
- The medication cupboards in each flat were fully equipped and emergency medications were all in date. Resuscitation equipment was in good working order, readily available and checked by staff to ensure it was fit for purpose and could be used effectively in an emergency. Figures provided by the service showed that 97% of staff had completed first aid awareness as an e-learning course. However, we spoke with the registered manager who informed us that they had become aware that this training did not include the use of a defibrillator. They were currently in the process of seeking classroom-based training in immediate life support and hoped to have all staff trained within the next few months. We were advised that should an emergency arise staff were aware to contact the emergency services.
- The service had appropriate processes in place for the management of clinical waste and staff were able to discuss these with us. We saw that staff disposed of sharp objects such as used needles and syringes appropriately in yellow bins and these were labelled correctly and not over-filled.
- We saw that the flats were cleaned to a good standard. There was a routine cleaning schedule held by the support staff in the hospital, which described areas to be cleaned. Domestic staff were not employed by the provider. Cleaning records were completed and up to date. There were regular checks of the fridge temperatures and all were recorded to be in the safe range. The flats were well maintained, as were the furniture, fixtures and fittings.
- Alarms were in place in both of the self-contained flats. Staff were issued with keys and personal alarms. The location of any triggered alarm was sent through to staff pagers automatically.

Safe staffing

- The total number of whole time equivalent (WTE) substantive staff for the hospital was 33 (as at 24 September 2015). The total number of staff leaving in the previous twelve months was five WTE. The staff turnover in that time period was 15%.

Good

Wards for people with learning disabilities or autism

- Staff vacancy rates were 4% as at 24 September 2015. During the inspection, the registered manager told us that there was one vacancy for a qualified nurse and two vacancies for support workers across the service. The registered manager told us that the service was actively recruiting to fill the vacancies.
- We noted that the overall staff sickness absence level for the period ending 24 September 2015 was 4%.
- The registered manager told us that they did not used bank or agency staff. Shifts that needed to be covered due to annual leave or sickness were done so by permanent staff.
- Staff told us that leave was never cancelled due to staffing levels. Each patient had their own separate staffing care teams so they could always attend appointments and ensure their leave took place. Each patient had an allocated primary nurse care team.
- During the day, both patients had three members of staff with them, one of whom was qualified. At night, each patient had two members of staff with them but no qualified staff member remained on site. We discussed this with the registered manager as to whether a qualified member of staff should be on site at all times in case medication needed to be given. We were told that this had been risk assessed and there was a nurse on call system, which ensured that a nurse was no more than 20 minutes travel away from the hospital. We spoke with staff who informed us that they had never had to utilise the nurse on call system to request a nurse to attend at night.
- Medical cover was provided by one doctor who was not available on site but was contactable via telephone when needed and could attend if requested. We discussed this with the registered manager. We were informed that in the event of an emergency the staffing team would contact the emergency services. However, there were no systems in place to ensure adequate medical cover was in place should the doctor be off on annual leave or sickness. This was recognised by the team as a concern but at the time of the inspection no further action had been taken by the provider to resolve the concern.
- Staff received appropriate mandatory training. Most permanent staff had completed the training required in 17 different areas. This included training in safeguarding adults at risk, which 97% of staff had completed, fire safety awareness which 92% of staff had completed and MCA & DoLS awareness, which 88% of staff had completed.
- We reviewed the personnel files of five staff working in the hospital. These showed that checks were carried out on staff prior to them commencing employment with the service. These included checks with the Disclosure and Barring Service (DBS), reference checks, prospective employees' qualifications and professional registration.

Assessing and managing risk to patients and staff

- We reviewed two patients' care and treatment records. Both patients had a risk assessment. Staff completed a positive behavioural support plan for each patient. This identified the patient's potential triggers and warning signs for risk behaviours, such as aggression. The plan was individually tailored to the patient and included information on what actions staff should take and proactive and reactive strategies.
- We saw patients' risk information was reviewed regularly and documented. We saw that the reviews of risk were part of the multi-disciplinary care review process. Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was managed. For example, observation levels of patients might increase or decrease. Individual risk assessments took into account the patient's previous history as well as their current mental state.
- There were appropriate systems embedded with regards to safeguarding adults at risk and children. Safeguarding concerns were reviewed and discussed as part of individual supervision and team meetings. Staff had received training in safeguarding adults at risk and were aware of the hospital's safeguarding policy.
- Staff we spoke with had a good understanding of safeguarding issues and their responsibilities in relation to identifying and reporting allegations of abuse. Staff told us of the steps they would take in reporting allegations to the senior management team and felt confident in contacting them for advice when needed.
- We found evidence of good management of medicines. For example, we saw that medicines were stored securely in each of the self-contained flats and monitored monthly. Temperature records were kept of the medicines fridge in which medicines were stored

which meant medicines remained fit for use. Prescription charts were completed correctly. However, the service did not undertake a full medication audit and had no input from a pharmacy team.

- Staff had been trained in the use of physical restraint and understood that this should only be used as a last resort. Guidance published by The Department of Health in April 2014 called 'Positive and Proactive Care' states providers should aim to reduce the use of all restrictive interventions and focus on the use of preventative approaches and de-escalation. We reviewed both patients care records and found that de-escalation or positive behaviour support was used proactively. The provider reported no incidents of restraint in the last six months prior to the inspection. Staff told us that the reduction in the use of restraint was due to the practice of 'reactive withdrawal' when the patient became distressed.
- There were 117 incidents of the use of seclusion in the last six months prior to the inspection. We spoke to staff who told us that due to the use of 'reactive withdrawal' when a patient is distressed, there were times when a patient would be locked in a room for a very short period of time to safely enable the nurse to get medication. Through lessons learnt the team recognised this as seclusion and so the decision was taken that all such incidents will be reported as so. We reviewed the most recent episode for each patient and found them to be clearly documented and were reviewed by senior managers to ensure that learning took place.
- The senior management team reviewed and reflected on incidents of physical restraint and we were told that these were discussed during handover,multidisciplinary team reviews (MDT) and practice workshops. These were tailored specifically to working with each patient.

Track record on safety

- The provider reported that there were no serious incidents requiring investigation (SIRI) in the last 12 months.

Reporting incidents and learning from when things go wrong

- Staff were familiar with the incident reporting process and all staff could report incidents. Staff demonstrated their knowledge about what incidents should be reported and how to report on their electronic record system, Datix. Datix is an electronic patient safety and risk management system that staff use to report an incident, near miss, complaint or concern. These were reviewed by the senior management team and discussed in the daily handover meetings, and MDT reviews.
- The senior management team ensured that where appropriate incidents were reported to NHS England and the Care Quality Commission.
- De-briefing for staff took place after incidents. Reflective practice sessions took place to enable staff to discuss any incidents that had occurred and encourage learning from. Staff told us they felt well supported by their colleagues and management team.
- Feedback of incidents was done through team meetings and practice workshops. These were tailored to the individual patients needs and took place every four weeks. Lessons learnt was a way for the senior management team to communicate what had been learnt from the reported incidents. For example, it was recognised that as a result of using reactive withdrawal as a behavioural management strategy for each patient, there were occasions when the patient may be briefly locked in a room so that medication could be sought. The team recognised that this was seclusion and all episodes were being recorded as an incident.
- The service had a duty of candour policy. Staff we spoke with were familiar with the policy and understood that they had a duty to be open and transparent with patients in relation to their care and treatment and the need to apologise when things go wrong.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Patients' needs were assessed and care was delivered in line with their individual care plans.
- Records showed that all patients received a physical health assessment and that risks to physical health were identified and managed effectively. Where physical

health concerns were identified care plans were put in place to ensure the patient's needs were met and the appropriate clinical observations were carried out. Both patients were registered with the dentist and general practitioner. Physical health checks such as ECG's (Electrocardiogram) and well-man checks were offered to patients and carried out when required. Where the patient lacked capacity, staff carried out best interest assessments.

- Care plans were personalised, holistic and recovery oriented. Staff used the care programme approach (CPA) for planning and evaluating care and treatment. In addition, both patients had a "Behavioural Support Plan". These were reviewed and updated on a regular basis.
- Records were computer and paper based, kept in good order and were accessible to staff at all times.

Best practice in treatment and care

- Patients had access to good psychological therapies recommended by NICE as part of their treatment on a one to one basis. The patient's individualised treatment programme was tailored to their needs.
- Psychologists and occupational therapists were an active part of the multi-disciplinary team.
- Physical health observations such as weight monitoring and blood pressure checks were carried out regularly and more frequently when needed. Patients were able to access the GP via the surgery or the GP would visit the hospital if this was not possible. Physical health checks were taking place where needed and referrals to specialists were made via the GP. Patients had access to the dentist and optician.
- The ward staff assessed the patients using the Health of the Nation Outcome Scales (HoNOS). These scales covered 12 health and social care domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions.
- Staff participated in clinical audits to monitor the effectiveness of services provided. The internal toolkit used was the IQuAT audit report (internal quality assessment tool) and was last completed in June 2015. Areas looked at included discharge planning, medication management and staffing. However, the provider had not implemented the green light toolkit. The green light toolkit is an audit that care providers carry out to look at improving mental health services to make them more effective in supporting people with learning disabilities and autism. We discussed this with the registered manager who informed us that the senior management team were aware of the need for more participation in clinical audits and this was currently being reviewed. The lack of clinical audit programme featured on the providers risk register. The provider reported that no CQUIN (Commissioning for quality and innovation) framework targets had been set by the CCG commissioners in the contract for this service.

Skilled staff to deliver care

- The staff working in the self-contained flats came from a range of professional backgrounds including nursing, medical, occupational therapy, psychology and social work. The provider only directly employed the nursing and support worker staff. They had a service level agreement in place with other members of staff from the multi-disciplinary team.
- Staff received appropriate training. Staff told us they had undertaken training specific to their role including safeguarding adults at risk, risk management, management of violence and aggression and de-escalation techniques. Records showed that most staff were up-to-date with statutory and mandatory training. Training was delivered face to face or via computer based e-learning. Staff also received training specific to the individual needs of the patients through regular practice workshops. For example, the use of communication tools to support staff in using Makaton sign language.
- All staff we spoke to said they received individual supervision approximately every four to six weeks. Staff told us they valued the supervision they received and felt well supported. Staff also told us that they could speak with managers and peers informally at any time and did not have to wait for formal supervision.
- The registered manager told us that the doctor engaged in clinical work in the service had undergone professional revalidation.
- Staff told us they participated in regular reflective practice sessions where they were able to reflect on their practice and incidents that had occurred. For example, de-briefing meetings took place following an incident. Staff were able to discuss what went well, what could have been improved and talk about how they felt.
- There were regular team meetings and staff told us they felt well supported by their local management structure and colleagues. Staff morale was good.

Good

Wards for people with learning disabilities or autism

Multi-disciplinary and inter-agency team work

- A multidisciplinary team meeting (MDT) was composed of members of health and social care professionals. The MDT collaborated to make treatment recommendations that facilitate quality patient care.
- Staff told us that MDT meetings took place every six weeks and both patients clinical care was reviewed with a focus on sharing information, patient treatment and reviewing the patient's progress and risk management.
- At the time of the inspection support workers were not invited to attend the MDT reviews but the registered manager told us that they planned to involve them in future reviews as they worked directly with the patients and could feedback more effectively to the MDT team as to what was or was not working so well.
- We found evidence of inter-agency working taking place. Care co-ordinators confirmed with us that they were invited to and attended meetings as part of patients' admission and discharge planning. The wards had a link with a local general practitioner and access to other specialist services when needed.

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

- We reviewed the training records and found that no staff had completed training in the MHA, as it was not considered mandatory training by the provider.
- Patients capacity to consent to treatment was recorded and assessed on admission and then regularly throughout and in multidisciplinary team meetings. The registered manager told us that during these meetings each patient's capacity and detention status was discussed and reviewed.
- Medication certificates were in place and copies had been attached to the medication charts. Medicine for mental disorder maybe administered to a patient either with his/her capable consent (T2) or, if s/he withholds consent or is incapable of giving consent (T3) authorisation by a second opinion appointed doctor (SOAD). However, it was noted that in some cases, these were over twelve months old and new certificates had not been renewed when patients' detentions had been renewed. Best practice would be to renew T2 certificates at 12 monthly intervals for T3 certificates at 24 monthly intervals.
- Patients had their rights under the Mental Health Act explained to them routinely and in an appropriate way that they would understand. This was clearly documented and their level of understanding was recorded.
- A standardised system of authorising leave was in place. All forms were in date and the parameters were clear. Expired section 17 leave forms were scored through or removed from patients care records, as per the MHA code of practice. Neither of the patients were offered a copy of the Section 17 leave form due to their levels of comprehension.
- Patients had access to an independent Mental Health Act advocate (IMHA).

Good practice in applying the Mental Capacity Act.

- There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy.
- We saw that staff completed Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) e-learning training. At the time of the inspection, 88% of staff had completed this training.
- Staff we spoke with demonstrated a good understanding and knowledge of the Mental Capacity Act (MCA) and of the hospital policy. Capacity to consent was assessed by staff on admission of a patient and then regularly throughout. One patient required specialist healthcare but lacked capacity to consent. We saw evidence that staff carried out best interest assessments and worked with the patient to prepare and support them. Staff told us that they would speak with the senior management team if they needed guidance.
- At the time of our inspection, there were no patients subject to a DoLS authorisation and no applications had been made.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

Good

Wards for people with learning disabilities or autism

- The patient we spoke with was positive about the staff. The interactions we observed between patients and staff were friendly and respectful. Staff responded to patients needs in a calm and respectful manner.
- Patients told us they felt safe in their surroundings. They felt well supported by staff who listened to their needs and treated them with respect whilst promoting their independence. For example, in one of the self-contained flats the patient proudly showed us around and pointed out the furniture and decoration. They had been supported by staff to choose their own wallpaper and pictures.
- Feedback received from relatives was good and praised the care and support provided by staff to patients.
- When staff spoke with us about patients, they discussed them in a respectful manner. Staff appeared interested and engaged in providing quality care to patients. We observed staff continuously interacting with patients in a positive and caring manner and they responded promptly to requests for assistance whilst promoting patients dignity and independence.
- Staff we spoke with had a good understanding of individual needs of patients. This was demonstrated in individual discussions with staff. Staff had good knowledge on how to de-escalate situations and worked as a team to promote a safe environment for both patients and staff.

The involvement of people in the care they receive

- We reviewed two care and treatment records and found that both patients had their care plans reviewed regularly with the multidisciplinary care team in reviews and with a member of their nursing team. Staff sought patients' views and clearly documented these. For example, patients' wishes and strengths were documented in care plans.
- Independent mental health advocacy (IMHA) was available from a local independent organisation. We found that the IMHA had assessed one patient and found that the IMHA service was not appropriate due to the patient's level of disability. We could not find any evidence that an independent mental capacity act (IMCA) had been contacted following this assessment.
- We observed staff involving patients in making decisions about their care. Staff sought the patient's agreement throughout. For example, whilst the inspection team were having a tour of the flats the staff asked the patient if it was ok for us to come in and have a look around and supported them in engaging in discussions with the inspecting team.
- Both patients had nearest relatives and they were actively involved in the patients care. Information was shared with relatives according to the patient's wishes or best interests. Although the provider did not seek formal feedback from the relatives/carers in the form of surveys etc., staff did speak with relatives regularly and this was clearly documented in the patients care records.
- Staff informed us that both patients did feedback what they did and did not like however, no formal community meetings or patient surveys were currently taking place.
- Both patients had advance directives in place.

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

(for example, to feedback?)

Good

Access and discharge

- The service provided for both patients was specific for their individual long term needs. No plans were in place for discharge or for other patients to access the service.

The facilities promote recovery, comfort, dignity and confidentiality

- Both self-contained flats were on the ground floor. Each flat was spacious with a separate lounge, dining room, bedroom, bathroom and access to outside space. Each flat was decorated differently based on the individual patient's needs and likes. Staff had personalised both patients flats by putting up pictures of memorable occasions and photographs. One self-contained flat had a sensory room for the patient to use. The other self-contained flat had been decorated with wallpaper and pictures, which were chosen by the patient. Outside each flat, an introduction to the patient was displayed showing the patients preferences and how they would like you to visit.
- There was a varied menu choice available and staff facilitated the cooking on site. Cultural and religious

foods were available on request. The kitchens were kept locked but patients had supervised access and were supported to cook. Hot and cold drinks were available at all times and staff supported patients in making these when requested to do so.

- Therapeutic activities were varied, recovery focused and aimed to motivate the patients and integrate them into the community. We saw that the activities programme was individualised to the needs of the patient and included swimming, horse riding, cooking and shopping.

Meeting the needs of all people who use the service

- Staff respected patients' diversity and human rights. Attempts were made to meet people's individual needs including cultural, language and religious needs. Staff assessed this during admission and reviewed it throughout the patient's stay. The registered manager informed us that they had arrangements in place should either patient wish to meet with a chaplain or seek spiritual support.
- Staff received training in equality and diversity as part of their mandatory training. We reviewed training records and found that 97% of staff had completed the training within the last three years.
- Patients spoke English as a first language and one patient communicated via Makaton sign language. Staff told us that interpreters were available to help assess patients' needs and explain their rights, as well as their care and treatment, but they had not needed to use them.
- Choices of meals were available and freshly cooked on site by staff. A varied menu enabled patients with particular dietary needs connected to their religion, and others with particular individual needs to access appropriate meals.
- One patient communicated through the use of Makaton sign language. A speech and language therapist had developed aids to support the patient in making choices and help staff understand through objects of reference and picture boards.

Listening to and learning from concerns and complaints

- The patient we spoke with felt confident that they could raise a complaint and would speak to their staff but had not needed to do so. Staff were aware of the process for managing complaints and told us that they would initially try and deal with it. If not able to do so, they would escalate to the nurse or senior management team.
- Over the last 12 months there had been two complaints received. One complaint was not upheld and no further details were provided about the second complaint.

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

Good

Vision and values

- Staff were aware of the organisations vision and values.
- Staff told us that they felt well supported by the service and the organisation. Staff said they were well supported by their peers and managers.

Good governance

- There were effective systems in place to ensure staff received supervision, appraisals and professional development. Staff told us that they had regular supervision.
- There were effective systems in place to ensure staff received training. However, training in the Mental Health Act was not part of the provider's mandatory training requirements. Records provided by the service showed that no staff from the service had completed the training.
- Staff told us they had undertaken training specific to their role, which was facilitated through practice workshops specific to the needs of the patients they were working with. For example, positive behavioural support.
- Data was collected regularly on performance. We saw that performance was recorded against a range of indicators, which included safeguarding, complaints, serious incidents and types of incidents. This was regularly reviewed at governance meetings and trends were monitored. Where performance did not meet the expected standard action plans were put in place and implemented to improve performance.

Good

Wards for people with learning disabilities or autism

- The learning from complaints and serious incidents was identified and actions were planned to improve the service when needed.
- Staff participated in some clinical audits to monitor the effectiveness of services provided. The internal toolkit used was the IQuAT Audit report and was last completed in June 2015. Areas looked at included discharge planning, medication management and staffing. However, the provider had not implemented the green light toolkit. The lack of clinical audit programme featured on the providers risk register.
- Staff used outcome measures such Health of the Nation Outcome Scales (HoNOS) to identify whether people improved following treatment and care.
- The registered manager told us they were encouraged and supported to manage the service autonomously. They also said that where they had concerns these could be raised and were appropriately placed on the service's risk register.
- We reviewed the personnel files of five staff working in the hospital. These showed that checks were carried out on staff prior to them commencing employment with the service. These included checks with the Disclosure and Barring Service (DBS), referencing, prospective employees' qualifications and professional registration.
- The Mental Health and Learning Disability Data Set (MHLDDS) require all services who have detained patients to submit data on a yearly basis. We discussed this with the registered manager who was unsure if the service completed this but assured us they would raise this with the team.

Leadership, morale and staff engagement

- Sickness and absence rates for permanent staff for the period ending 24 September 2015 was 4%.
- At the time of our inspection, there were no grievance procedures, allegations of bullying or harassment reported across the service.
- Staff told us they were aware of the whistle-blowing process and were confident they could raise concerns if needed.
- Staff demonstrated that they were motivated and dedicated to deliver the best care and treatment they could for the patients. There was good staff morale across the service. All the staff we spoke with were enthusiastic and proud with regards to their work and the care they provided for patients.
- The culture of the service was open and transparent with a drive for continual improvement. Staff told us they were encouraged and supported to discuss ideas within the team. The service had a Duty of candour policy. Staff that we spoke with were familiar with the policy and informed us that they were aware of their individual responsibilities to be open and transparent in respect of patients care and treatment. They also told us that they felt well supported by the managers to be open and honest.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should review staff training to include the use of a defibrillator.
- The provider should review their medication audits and lack of pharmacy input and support.
- The provider should review their arrangements for medical cover to ensure that when the doctor is on annual leave or sickness access to another doctor is availaible if needed.
- The provider should consider appropriate training for all staff in the use of the Mental Health Act.
- The provider should review how they seek feedback from patients and relatives/carers.
- The provider should review medication certificates. Best practice would be to renew T2 certificates at 12 monthly intervals, for T3 certificates at 24 monthly intervals.
- The provider should review their lack of participation in clinical audits, particularly with regard to the green light toolkit.
- The provider should ensure that they submit data to the Mental Health and Learning Disability Data Set and Mental Health Services Data Set.