St Andrew's Healthcare - Mens Service

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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

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

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

Summary of findings

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

Overall summary

We rated Men's services as requires improvement because:

- Seclusion practices were not compliant with the Mental Health Act code of practice. Medical and nursing reviews had not taken place as required in 36% of records checked. Staff had not completed seclusion care plans for patients in 70% of records checked.
- Doctors advised that they were not always able to complete seclusion reviews within the timescales required by the Mental Health Act code of practice. We reviewed data for weekend on call provision, which evidenced that the demands on doctors providing this support exceeded available on call medical staffing.
- Managers had not identified all environmental risks in patient areas on forensic, learning disabilities and older adult's wards. We found unidentified ligature risks and blind spots.
- The provider had not ensured that all risk assessments and care plans were in place and updated consistently in line with changes to patients' needs or risks.
- The provider had not ensured that patients' physical healthcare needs were met in accordance with care plans. There was no out of hours physical healthcare provision on site.
- Managers had not ensured that all patients requiring observation had appropriate care plans.
- Staff had not created personal emergency evacuation plans for patients with restricted mobility on the older adult's wards. Staff had limited access to specialist equipment for moving patients with restricted mobility down stairs in the event of a fire.
- Staff had not followed safe procedures for the recording of medicines administration on one forensic ward.
- We found issues with cleanliness and maintenance on the forensic and learning disabilities wards.
- The provider had not ensured all medical equipment was regularly tested to check it was in working order. On upper Harlestone ward, we found staff had not regularly tested the oximeter and blood pressure machine.
- The decor and furnishings on Foster ward were poor.
- There were insufficient numbers of staff to provide safe care, treatment and access to leave and activities on the forensic, older adults and learning disabilities wards.
- There was a lack of consistent management on Foster and Harlestone wards.
- The provider had implemented changes to staff roles without fully assessing the impact and had not communicated the changes effectively.

However:

- Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw that staff were responsive to patient's needs.
- Staff were open and transparent and would explain to patients and carers when things went wrong.
- Staff knew what constituted a safeguarding, and could explain the process of reporting and escalation to senior staff. Staff put protection plans in place for patients when required.
- Staff had access to appropriate alarms and radios to call for help in the event of an emergency.
- Staff reported incidents in line with policy. Senior staff cascaded information about lessons learnt to staff at ward level.
- Staff were aware of the provider's whistleblowing policy and were confident they could raise concerns without fear of reprisals. Staff spoke positively about the support received from managers.
- Ward managers were able to adjust staffing levels to meet the changing needs of patients requiring high levels of monitoring linked to individual patient risks.

Summary of findings

- Wards had fully equipped clinic rooms with access to resuscitation equipment, which was regularly checked and maintained.
- Staff had a good knowledge of the Mental Health Act and Mental Capacity Act.
- Wards had a variety of rooms for patients to use including quiet, therapy, fitness and activity rooms.
- Staff had good access to training and received the necessary specialist training for their roles.
- The provider held regular governance meetings to monitor the service. Managers used key performance indicators to monitor their wards performance.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good	Heygate ward
Forensic inpatient/ secure wards	Requires improvement	Robinson ward Fairbairn ward Prichard ward
Long stay/ rehabilitation mental health wards for working-age adults	Good	Ashby ward Fenwick ward Church ward
Wards for older people with mental health problems	Requires improvement	Foster ward Cranford ward
Wards for people with learning disabilities or autism	Requires improvement	Hawkins ward Naseby ward Mackaness ward Harlestone ward Watkins House Garden Cottage

Summary of findings

Contents

Requires improvement

St Andrew’s Healthcare

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults; Wards for older people with mental health problems; Wards for people with learning disabilities or autism;

Summary of this inspection

Background to St Andrew's Healthcare - Mens Service

St Andrew's Healthcare Northampton has been registered with the Care Quality Commission since 11 April 2011. The services have a registered manager and a controlled drug accountable officer. The registered locations at Northampton are adolescent services, men's services, women's services and acquired brain injury (neuropsychiatry) services.

Northampton is a large site consisting of more than ten buildings, more than 50 wards and has 659 beds.

St Andrew's Healthcare also has services in Nottinghamshire, Birmingham and Essex.

These locations at St Andrew's Healthcare Northampton have been inspected 21 times. The last inspection was in May 2017. This was a focused inspection. There was a further focused inspection in January 2018, which looked at the actions taken by the provider following the warning notice issued after the May 2017 inspection. The provider had addressed the majority of concerns. We identified issues remained in regards to medical reviews of patients in seclusion and managers providing management supervision to staff.

The service is in the process of transferring from care pathways to integrated practice units. These units consist of wards providing the same specialism, for example, the psychiatric intensive care units formed one integrated practice unit.

The following services were visited on this inspection:

Forensic inpatient/secure wards:

There are three wards at the Northampton Men's service providing forensic inpatient/secure services for men of working age. All patients receiving treatment in this service are detained under the Mental Health Act.

We inspected the following wards:

- Robinson ward is a medium secure ward with 17 beds.
- Fairbairn ward is a medium secure ward with 17 beds for people with impaired hearing.
- Prichard ward is a medium secure ward with 17 beds.

Long stay/rehabilitation wards for working age adults:

There are three wards providing rehabilitation support to patients. We inspected:

- Ashby ward (previously Ferguson ward) provides support for up to 16 male patients in a locked rehabilitation environment.
- Church ward provides support for up to 10 male patients in a low secure environment.
- Fenwick ward provides support for up to 10 male patients in a low secure environment.

Wards for people with learning disabilities or autism:

The services for patients with learning disabilities and autism provide inpatient accommodation for patients with learning disabilities over the age of 18 years. We inspected the following wards:

- Hawkins ward, a 15 bed medium secure service for men with learning disabilities and forensic challenging behaviour.
- Harlestone ward, a 20 bed male low secure ward for people with autistic spectrum disorder.
- Naseby ward, a 15 bed service for men with mild/ borderline learning disabilities.
- Mackaness ward, a 15 bed a male medium secure ward for people with autistic spectrum disorder.
- Garden Cottage, a five bedded locked house for people with autistic spectrum disorder.
- Watkins House, a six bedded house in a local residential area.

The learning disabilities wards provide care and treatment for adults with mild to moderate learning disabilities and other neuro-developmental disorders who have offended or display behaviour which challenges. People in the autism services have co-existing conditions such as mental and physical illness or additional developmental disorders such as personality disorder which put themselves or others at risk.

Acute wards for adults of working age and psychiatric intensive care units:

- Heygate ward is a psychiatric intensive care unit with 10 beds.

Summary of this inspection

Wards for older people with mental health problems:

- Foster is a locked ward with 15 beds.
- Cranford is a medium secure ward with 17 beds.

This was a comprehensive announced inspection, looking at all key questions.

Our inspection team

Team leader: Helen Kirton

The team that inspected this service comprised three Care Quality Commission inspection managers, nine Care Quality Commission inspectors, one Care Quality Commission member of the medicines team, nine specialist nurse advisors and three experts by experience. Experts by experience are people who have experience of using services or for caring for someone who has used services.

The team would like to thank all those who met and spoke with them during the inspection and who shared their experiences and perceptions of the quality of care and treatment at the service.

Why we carried out this inspection

We undertook this inspection to find out whether St Andrew's Healthcare men's services in Northampton had made improvements to their forensic, rehabilitation, psychiatric intensive care unit, learning disability and older people services since our last inspection of this location in May 2017.

When we last inspected the Northampton men's service in May 2017, the overall rating for this location was inadequate. We rated the safe and well-led key questions as inadequate for forensic and long stay/rehabilitation services. We rated the safe and effective key questions as requires improvement for the learning disability service and the safe key question as requires improvement for the psychiatric intensive care unit. In May 2017, we rated the older adult's core service as good across all key questions. We carried out a focused unannounced inspection of the forensic, rehabilitation and psychiatric intensive care unit wards in January 2018 to follow up compliance with the warning notice issued after the May 2017 inspection.

Following the May 2017 inspection, we issued a Section 29 warning notice and requirement notices and told the provider to take the following actions:

- The provider must ensure that the environment is well maintained, safe and that it is clean. The provider must ensure all patient risk assessments and care plans include how staff will manage specific environmental ligature risks.
- The provider must ensure the prevention, detection and control of infection.
- The provider must ensure the governance processes are operationally effective and identify issues.
- The provider must ensure there are sufficient numbers of suitably qualified, competent, skilled, and experienced persons deployed to meet the needs of all patients using the service, including adequate medical cover at night.
- The provider must ensure policies meet the Mental Health Act code of practice and that staff are fully aware of terminology and required practice.
- The provider must ensure accurate, complete and contemporaneous records are kept.
- The provider must ensure that privacy and dignity is maintained at all times.
- The provider must ensure equipment is up to date with safety testing and within expiry dates.
- The provider must address the issue of staff being trained in two types of physical intervention approaches to ensure staff and patient safety.

Summary of this inspection

- The provider must ensure the proper and safe management of medicines and ensure prescribing is in line with the National Institute of Health and Care Excellence.

These were in relation to the following regulations:

Regulation 10 Dignity and respect

Regulation 12 Safe care and treatment

Regulation 17 Good governance

Regulation 18 Staffing

Following the January 2018 inspection we issued requirement notices and told the provider to take the following action:

- The provider must ensure medical and nursing staff complete seclusion reviews as required in line with the Mental Health Act code of practice and that staff fully complete seclusion documentation.
- The provider must ensure that staff receive management supervision in line with their policy.

These were in relation to the following regulations:

Regulation 12 Safe care and treatment

Regulation 18 Staffing

We also said:

- The provider should ensure that qualified staff shifts are filled.
- The provider should ensure that seclusion facilities meet the specialist needs of patients and that seclusion clocks display the correct time.
- The provider should ensure that staff complete detailed risk assessments for all patients.
- The provider should ensure that all actions identified on ligature audits include a timescale for actions to be completed.

We have identified the issues which remain later in this report, the provider had addressed most but not all of these actions from the May 2017 and January 2018 inspection.

How we carried out this inspection

This was an announced inspection. We carried out this inspection as a comprehensive inspection. We inspected all key questions for all services.

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

During the inspection visit, the inspection team:

- held staff focus groups prior to the inspection
- visited 15 wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 57 patients who were using the service
- spoke with eight carers
- interviewed the manager or acting manager for each of the 15 wards inspected
- interviewed the senior management team for the men's service
- spoke with 92 other staff members; including doctors, nurses, healthcare assistants, psychologists, occupational therapists, social workers and activities coordinators
- looked at 80 care records
- reviewed 65 prescription charts and inspected medicines management
- attended five handovers, four multidisciplinary meetings and one safeguarding meeting
- inspected 11 seclusion facilities and reviewed 36 seclusion records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 57 patients who were using the service.

- Most patients we spoke with told us that they felt safe. Patients said they felt relaxed and that staff were competent in their roles.

Summary of this inspection

- Patients told us that staff were helpful, caring, kind and approachable and were visible and around when you needed them.
- Patients we spoke with told us that staff listened to their concerns when raised, for example, in community meetings.
- Patients knew how to make a complaint. One patient told us that they had raised a complaint, which staff acted upon.
- Patients on some wards told us there were sufficient activities to keep them occupied during the week and at weekend. One patient said he would prefer to stay in their current service than move on to a low secure ward because of the variety of occupational activity available to them.
- Patients said that the quality of the food had improved and most had access to snacks and drinks whenever they wanted them.
- Patients on most wards told us they were involved in their care plans, and received a copy if they wanted one.
- Patients reported the ward environment was clean and tidy.
- Patients said staff knocked on their doors before entering their bedroom to give privacy.
- One patient told us staff were helping them buy a laptop so they could type letters. Another patient told us they enjoyed going to the woodwork club to make items. A patient told us staff assisted them to purchase specific products to meet their cultural skin care and hair care needs.

However:

- Fourteen patients told us that due to staffing levels, they were not always able to have authorised leave or attend planned activities. Some patients said they could not access hot drinks during the night.
- Four patients said that they did not get a chance to go to the multi-disciplinary meeting to discuss their care and treatment. One patient said that you had to request if you wanted to speak with the doctor.
- Two patients told us there was nothing to do on wards. One patient on Foster ward said they were frightened of one patient and felt it was worse some nights when the regular staff were not around.
- Another patient on Robinson ward told us he felt that staff bullied patients and that he was less likely to get his leave when certain staff were on shift.
- Two patients said that they would not make a complaint as they thought it could “backfire” on them in some way.

We spoke with eight carers.

- They told us they felt assured that their relatives were safe. One carer praised the service saying their son was the best he has been since being on Prichard ward and there were plans for him to move on. They said that staff kept them informed of changes following ward round meetings either by phone or in writing. They said that staff were very friendly and there was good access to activities both on and off the ward for their loved one.

However:

- One carer expressed concern at staffing levels on Prichard ward. They said their relative did not receive the twice weekly full hour psychology session, having 30 minutes once a week. They were also concerned that there was no longer a full time social worker for this ward.

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?

Requires improvement 

We rated safe as requires improvement because:

- Seclusion practices were not compliant with the Mental Health Act code of practice. Medical and nursing reviews had not taken place as required in 36% of records checked. Staff had not completed seclusion care plans for patients in 70% of records checked.
- Doctors advised that they were not always able to complete seclusion reviews within the timescales required by the Mental Health Act code of practice. Demand on doctor's time outstripped supply. They provided additional data relating to weekend on call cover for 30 weekend days from August 2017 to March 2018. In total 368 tasks were provided over 88 hours. Of these 212 (58%) were seclusion tasks which in themselves equated to 88 hours.
- We identified three blind spots in seclusion facilities on the forensic and learning disability wards. On Naseby ward there was a blind spot between the seclusion and en-suite area. We identified blind spots in the en- suites of both seclusion rooms on Robinson ward.
- Managers had not identified all environmental risks in patient areas. These included ligature risks in the secret garden shared by Fairbairn and Prichard wards. The extra care suite on Prichard ward had a sharp door fitting on the door to the living area on which patients may harm themselves. On Foster ward staff were unaware of the ligature risk audit. The audit was incomplete and did not include all rooms. On Foster, we found equipment, which displayed stickers with safety testing dates of 2016. There were exposed electrical cables behind the door leading to staff offices. On Foster, handrails to help prevent patients with mobility problems from falling were not in all communal areas of the ward.
- The provider had not ensured that all risk assessments were in place and updated consistently in line with changes to patients' needs or risks.
- Foster ward was based over the first and second floors of the building. Staff had not created personal emergency evacuation plans for patients. The provider had a limited amount of specialist equipment (slide slings but no evacuation chairs) for moving patients with poor mobility down the stairs in the event

of a fire. Staff did not have a clear understanding of fire processes and procedures. Access to the ward for people with reduced mobility was via a lift, which was not working during the inspection.

- On Foster ward, staff used plastic bags to line rubbish bins on the ward. We found a roll of large orange plastic bags on a shelf in the corridor area. Plastic bags were not allowed on the wards as they presented a risk to patient's safety.
- Staff were not always following the provider's policy for observing patients on the forensic and learning disabilities wards.
- We observed a medication round on a forensic ward using the electronic prescribing system. The registered nurse did not sign for each individual patient following administration of their medication and instead signed the electronic administration record for all patients having completed the round. This meant there was a delay and could have led to errors in the signing for medication that had been given.
- The provider had not ensured all medical equipment was regularly tested to ensure it was in working order. On upper Harlestone ward, we found staff had not regularly tested the oximeter and blood pressure machine.
- We identified issues with cleanliness on Prichard, upper Harlestone and Watkins House. The therapeutic kitchen on Prichard ward was dirty with paint flaking from the windowsill, the laminate coating had come off the worktop and there was perishing food in the fridge. Kitchen surfaces, fridges and the freezer on upper Harlestone, and the fridge, toilet and shower at Watkins House were not clean.
- We identified issues with maintenance on Prichard and Foster wards. The toilet on the bedroom corridor on Prichard ward had a leak under the sink and the laminate floor was stained. On Foster, curtains were hanging off the rail in the main lounge area. Paint was peeling in the dining area. There was a burst pipe in the kitchen that had burst previously. A bucket was placed underneath to catch the water.
- Foster ward's décor and furnishings were poor. The ward and one bedroom had an underlying unpleasant smell.
- The kitchen fridge on each of the rehabilitation wards contained open items of food. Labels were not in place indicating when the food had been opened and when it should have been consumed by.
- There were insufficient staff to facilitate patients section 17 leave on forensic, learning disabilities and older adult's wards.

Summary of this inspection

- We reviewed the provider's incident database. As of 28 March 2018 there were 360 incidents awaiting review, of which 263 were overdue.
- Staff turnover on Foster ward, including management positions over the past 12 months was high.

However:

- Staff observed areas of the ward that were not in direct lines of sight as part of routine ward observations. There were convex mirrors and closed circuit television in areas such as the bedroom corridors where there were blind spots in order to mitigate against incidents.
- Each ward had a fully equipped clinic room with access to resuscitation equipment.
- There was clear signage reminding staff to adhere to infection control principles including handwashing.
- Staff had access to appropriate alarms and radios to call for help in the event of emergency.
- Staff had a good understanding of the safeguarding reporting process. Staff put protection plans in place as required. There were safe procedures for families and carers including children to visit the hospital.
- Ward managers were able to adjust the staffing levels to take account of case mix. We saw examples of shifts where staffing had been increased to take account of patients who required increased observation. When bank and agency staff were used, they were primarily sourced through the provider's bank bureau, agency staff were used as a last resort.
- Qualified nurses were available in communal areas of the ward at all times.
- All permanent and bank staff were trained in the management of actual or potential aggression. Staff told us that they used restraint as a last resort.
- Staff reported incidents appropriately. Lessons learnt from incidents were cascaded to staff. Staff we spoke with said they received a debrief following serious incidents and felt well supported by their manager and the team.
- Staff were open and transparent and would explain to patients and carers when things went wrong.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- All information needed to deliver care was stored electronically and was available to staff when they needed it. There were also paper copies of personal behavioural support plans available in each ward office.
- The multidisciplinary team included the full range of mental health disciplines to provide care to this patient group and included occupational therapists, psychologists, social workers, nurses, health care assistants, activities coordinators, activity nurses and pharmacists.
- Staff used recognised rating scales to assess and record severity and outcomes including the Health of the Nation Outcome Scales. Robinson ward was a centre of excellence for the use of the Vona du Toit Model of Creative Ability.
- Patients accessed psychological therapies in line with the National Institute for Health and Care Excellence guidance; these included cognitive behavioural therapy, dialectical behavioural therapy and sex offender treatment programmes. There was reference made to the National Institute for Health and Care Excellence guidelines for patients with positive behaviour support care plans.
- Staff we spoke with said they had good access to training for their role and the provider had a programme for training healthcare assistants to become registered nurses.
- Staff had a good knowledge of the Mental Health Act and the Mental Capacity Act. Where patients were subjected to the Mental Health Act, staff protected their rights. The completion rate for Mental Health Act and Mental Capacity Act training was at 85%. There was a Mental Health Act office on site to help staff deal with any queries.

However:

- Patient records showed gaps in the recording and management of ongoing physical health problems. We found that staff had not always completed food and fluid balance charts for a patient with diabetes on Prichard ward. On the learning disabilities wards we found a number of gaps in the recording of patients' baseline observations, an example of a patient with asthma whose peak flow reading had not been recorded in line with the plan of care and a patient who had become hard of hearing who was not referred for an audiology appointment.
- There was no out of hours physical health care provision on site.

Summary of this inspection

- Staff had not always ensured patient records were complete or accurate and had not always updated them following incidents. Care plans were not available in an accessible form, for example in pictorial form for those patients who did not want or were not able to understand a lengthy paper document.
- Staff we spoke with said that there had been a reduction in the number of social workers and occupational therapists available to the forensic and older adult's service meaning that social workers were now providing support to more than one ward. One occupational therapist covered both Cranford and Foster ward. Patients said they had less access to occupational therapy sessions.
- Whilst the provider had made considerable progress in delivering supervision, they had not achieved their target of 85% of staff having regular clinical and managerial supervision. Staff on Foster ward had not received regular management supervision due to high rates of management turnover.
- In the older adults service, the conditions of section 17 leave did not always state if it was being granted as part of a rehabilitation plan or as a routine requirement to enable the patient to access fresh air. Staff did not consistently record when patients declined Section 17 leave.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw that staff were responsive to patient's needs, discreet and respectful.
- Most patients we spoke with told us that they felt safe and that staff took the time to listen to them when they had a problem.
- Carers we spoke with felt that they were appropriately involved in their relative's care. One carer praised the service saying their son was the best he has been since being on Prichard ward.
- The admission process informed patients about their care and orientated them to the wards and the service.
- Patients were involved in their care and treatment. We saw staff explaining to patients about aspects of their care and treatment. Patients signed care plans, where appropriate, to show their agreement. Patients were actively encouraged to be involved in their ward round and were offered a copy of their care plan. Patients said staff took into account their personal, cultural and social needs especially when planning activities.
- Patients had access to an independent mental health advocate who regularly visited the wards.

Summary of this inspection

However:

- We observed one member of staff was rather abrupt with a patient who had requested the remote control to change the channel on the television on Fairbairn ward.
- Not all patients had the opportunity to go into the weekly multi-disciplinary meeting to discuss their care and treatment on the psychiatric intensive care unit.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Managers advised that the service was not meeting the needs of five patients on Hawkins ward. Staff told us they had escalated this issue to senior managers.
- Space was limited on Foster ward. Staff were using rooms for dual purposes, for example, the staff room was also an interview room. There were no designated quiet rooms.
- We found privacy and dignity issues on Foster ward. Some bedrooms were off a corridor leading to the dining room and toilets/shower rooms. This meant other patients could see into the bedroom if the door was open as they passed along the corridor. The ward telephone was in a communal area. Patients could not make a phone call in a private area.
- We found issues with outside space on the older adult's wards. Foster ward was on the first floor and there was no direct access to the garden area. As a result, frail, elderly patients were reliant on staff availability to access fresh air. On Cranford ward, the outside courtyard was stark and bare.
- On Cranford ward, bed occupancy was 100%, which was above the Royal College of Psychiatrists recommended 85% to ensure quality of care.
- We found blanket restrictions on the older adult's wards. Access to food and drinks was restricted to set times. Patients could request snacks and drinks outside of these times, but staff could not always facilitate this if the ward was busy. On Foster ward there was a blanket ban on all patients using paper hand towels. Patients had to use toilet roll to dry their hands.

However:

- The service did not move patients between wards during their admission unless this was justified in their best interest. When patients were moved or discharged this happened at an appropriate time of day. Patients were discharged back to their home area, whenever possible.
- We saw that care plans referred to identified section 117 aftercare services for patients who had been subject to section 3 or the equivalent forensic section of the Mental Health Act.

Summary of this inspection

- Patients told us the food was of good quality. Food choices included halal, kosher and vegetarian meals.
- There were information leaflets available on treatments, how to make a complaint, the Mental Health Act and patient's rights, and advocacy in the main hospital reception. Patients had access to appropriate religious and spiritual support, there was a multi-faith room within the hospital and patients were provided with a suitable quiet space on the ward to pray.
- There were accessible bathrooms and toilet facilities on each ward for patients who required this. There was easy access to interpreters for those for whom English was not their first language. On Fairbairn ward, most staff were competent in British sign language or were undergoing training. There was a 50% mix of hearing impaired and hearing staff in an effort to promote the deaf culture.
- Staff knew how to handle complaints. Patients told us they were able to raise a complaint or issue in the community meetings, these issues were recorded and highlighted to staff in team handovers and with managers. Feedback was given to the complainant at the community meeting, where appropriate or to the patient on a one to one basis.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- We found a lack of leadership on some wards in the learning disability and older adult's service. There was a lack of management support on both Harlestone wards. On Foster ward there had been eight managerial changes over the last 24 months. The interim manager at the time of the inspection had only been in post for six weeks, a new manager was starting in June 2018.
- Staff on the learning disability and forensic wards told us that there was poor visibility of senior management. Forty percent of staff interviewed in the learning disability service told us they did not know who the senior managers in the organisation were and advised they had not seen them on the wards. Staff in the forensic service told us that senior managers rarely visited the wards.
- Staff did not have access to regular team meetings on Prichard, Mackaness and Harlestone wards.
- Managers had not ensured that there were sufficient numbers of staff on shift to enable patients to have regular sessions with their care coordinator. On the learning disability wards, 75% of staff interviewed expressed concerns about understaffing.

Summary of this inspection

- Staff told us morale had been affected by reductions in the multidisciplinary team, extra kitchen duties without replacement staff and the uncertainty of what independent practice units will mean for the service and their roles. Staff had taken on the responsibility of serving meals on the wards but managers had not ensured that staff were clear about their responsibilities and had not ensured staffing levels met demand.
- We received feedback from staff we spoke with that they had been told not to be negative at transformation meetings. Staff had therefore felt they could not express their views about service developments.
- Whilst the provider had made considerable progress embedding the importance of regular clinical and managerial supervision, managers had not met the target for supervision.

However:

- Staff were aware of the provider's whistleblowing policy and were confident they could raise concerns without fear of reprisals. There was also a 'safe call helpline', which staff could use anonymously to express any concerns.
- The service had governance structures in place. Monthly ward management meetings were held involving staff and patient representatives where learning was shared and there was evidence of this in meeting minutes. The provider used key performance indicators to measure the performance of the team, and monitored these in weekly governance meetings.
- Staff said they felt supported by the ward managers and in particular, staff from Prichard ward were pleased with the recent appointment of a new ward manager. Staff told us there was a high level of mutual support within the team.
- Staff described the provider's vision and values and explained how they implemented these in their care and treatment of patients. An example of this was putting people first and valuing each person as an individual. Team objectives reflected the organisations vision and values.
- Managers monitored staff compliance with their mandatory training. Compliance rates were 94%.
- Managers addressed staff performance promptly and effectively. One ward manager gave examples of recent incidents, which had led to disciplinary proceedings for staff.
- Managers and staff said that there were opportunities both internally and externally for training and development.

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.

- Seclusion practices were not compliant with the Mental Health Act code of practice. Medical and nursing reviews had not taken place as required in 36% of records checked. Staff had not completed seclusion care plans for patients in 70% of records checked.
- Foster ward did not have a seclusion room. Patients had to go through a small air lock and down stairs or use the lift, via the main building to access the seclusion room on another ward. This took five minutes to walk or a minute in a car. This presented a risk to patients and staff. The seclusion area was last used 19 March 2018. The manager reported seclusion was rarely used.
- Blanket restrictions were in place on the older adult's wards. Access to food and drinks were restricted to set times. Patients could request snacks and drinks outside of these times, but staff could not always facilitate this if the ward was busy. A blanket restriction was in place on Foster ward that meant that patients had to use toilet roll instead of paper towels to dry their hands, as one patient blocked the toilets by putting paper towels in the bowl.
- Patient leave entitlement was clearly documented in their records and outcomes from leave placed in progress notes. However, we identified examples of poor risk assessment completion prior to leave and in relation to activities completed during patient's escorted leave with staff. We identified some potentially punitive approaches to leave in relation to compliance with treatment for physical health conditions and attendance at community meetings. Fourteen patients told us that due to staffing levels, they were not always able to have authorised leave. Staff did not consistently record when patients declined section 17 leave.
- Mental Health Act training was mandatory for staff, 85% had completed this. Staff had a good understanding of the Mental Health Act, the code of practice and the guiding principles. The Mental Health Act team also provided additional training on request. The provider's own solicitor provided updates to the Mental Health Act team on changes to case law.
- Competent staff examined patient's Mental Health Act papers on admission to the hospital. The detention paperwork we reviewed had been filled in correctly, was stored appropriately and copies were scanned onto the electronic recording system.
- Staff said they knew who the Mental Health Act administrators were and could access their support when needed.
- We saw evidence that all prescriptions were accompanied by the correct consent to treatment forms and there was evidence in care records that doctors had assessed and documented capacity requirements.
- There was evidence in care records that patients had their rights under the Mental Health Act explained to them regularly. Staff had given patients leaflets explaining their rights and for deaf patients on Fairbairn ward, staff had given these in sign language and pictorial form.
- There were posters on each ward giving patient's information on how they could contact an independent mental health advocate. Patients told us that they had accessed advocates easily in the past and that an advocate regularly attended the wards. The Mental Health Act lead attended monthly advocacy meetings.
- There were regular audits to ensure staff were applying the Mental Health Act correctly. The provider had recently introduced an audit of seclusion practices, this had highlighted the issues we identified during the inspection.
- The provider was detaining all patients under the Mental Health Act at the time of inspection.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training was mandatory for staff, 85% had completed this. Staff were able to explain the main principles of the Act, and talk about how this may be applied in practice.
- The provider had a Mental Capacity Act policy and Deprivation of Liberty Safeguards available online that staff were familiar with and could refer to. Staff knew where to get advice regarding the Mental Capacity Act.
- For people who had impaired capacity, capacity to consent was assessed and recorded appropriately on a decision specific basis with regard to significant decisions. We saw evidence in care records that patients were given every possible assistance to make a decision themselves before they were deemed to lack mental capacity to make it.
- Appropriate Mental Capacity Act assessments, to establish capacity to consent to care and treatment, were completed. Staff discussed individual patient capacity in clinical reviews. Staff recorded this in care and treatment records.
- There were no informal patient on the wards we visited. Deprivation of Liberty Safeguards did not apply.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Forensic inpatient/ secure wards	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Long stay/ rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Acute wards for adults of working age and psychiatric intensive care units

Good

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Good

Safe and clean environment

- The layout of the building meant that staff were able to effectively observe all parts of the ward.
- There were identified ligature risks on the ward. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The ligature risk assessment was up to date and accurate. Staff recorded actions they took to minimise any risks.
- The ward was male only and was compliant with guidance on same sex accommodation.
- The clinic room was fully equipped along with a "grab bag" staff used in a medical emergency. Emergency medicines were accessible by staff if needed. They were secured with tamper proof seals. Checks were in place to ensure emergency medicines were available and in date.
- The seclusion room allowed clear observation, had a two way communication system, had toilet facilities and a clock. The room met the Mental Health Act code of practice guidelines.
- The ward appeared clean, had appropriate furnishings, and was well maintained.
- The provider had undertaken a full internal audit of infection control following the last inspection. This led to the introduction of an infection control assurance process, which includes unannounced reviews and spot checks. Staff adhered to infection control principles. We saw that protective aprons and gloves were available. There was adequate hand washing facilities and hand gel available to staff.
- Staff regularly cleaned the ward. We saw a dedicated team of housekeepers working throughout the inspection.
- Staff completed daily environmental checks, and reported any concerns to the ward manager.
- All staff had access to appropriate alarms and so could summon assistance as and when required. Staff tested alarms regularly.
- Patients had access to nurse on call systems to summon help when needed.

Safe staffing

- The service had an establishment of 12 qualified nurses, all of whom were in post. The service had an establishment of 15 healthcare assistants, of which only one post was vacant.
- The provider had estimated the number and grades of nurses required. We examined the rota for the past six weeks, and saw that the staffing requirements met the number of staff on most shifts. Agency use was minimal.
- The ward used bank staff that were familiar with the ward environment where possible. Between 1 October 2017 and 31 December 2017, 107 shifts had been covered using bank staff, to cover sickness, absence, and vacancies. During the same time, the service reported 18 shifts where agency staff were used. There was 50 shifts whereby bank or agency staff could not be sourced. Staff reported that they could use staff from other wards if necessary, or utilise the multi-disciplinary team, to ensure that patients' needs were met.

Acute wards for adults of working age and psychiatric intensive care units

Good

- The ward manager was able to adjust staffing levels on a daily basis in order to meet patient needs. For example, if a patient required supportive observations.
- There were qualified staff in communal areas at all times during the inspection.
- Staffing levels enabled the nurses to have one to one time with their named nurse / care co-ordinator. Staff recorded these in patient records.
- Patients with escorted leave were able to take their leave. Activities scheduled usually occurred and were rarely cancelled due to staffing issues.
- There was enough staff to undertake physical interventions (restraint) where necessary.
- The ward shared a consultant and an associate specialist with one other ward. There was appropriate medical cover throughout the day. Out of hours, there was an on call rota. Staff reported that generally they could access a doctor out of hours in a timely way.
- Staff received and attended mandatory training, which consisted of a number of courses. The services own target for staff mandatory training compliance was 95%. Most staff on Heygate ward had met this target.

Assessing and managing risk to patients and staff

- We examined eight care records. Staff undertook a risk assessment of every patient upon admission. Staff updated risk assessments following incidents. The risk assessment tool used was unique to St Andrews Healthcare.
- There were no blanket restrictions in place. Any restrictions made to individual patients were justified through an individual risk assessment, which the staff team had discussed with the patients.
- The hospital had appropriate policies in place for the use of observations, which staff followed as and when appropriate. Staff searched patients in line with hospital policy and was based upon risk.
- There had been 96 incidents of physical restraint of patients between 1 July 2017 and 31 December 2017. These restraints involved 24 different patients. Of these restraints, 25 had resulted in the prone (chest down) position (26%), and of these 15 patients received rapid tranquillisation. There had been a reduction in physical restraint compared to the last inspection, which reported 101 incidents of restraint over a six month period. Staff monitored the use of restraint at the restrictive practice monitoring group, which occurred monthly.
- Staff emphasised that they used physical restraint as a last resort, in line with training. Staff attempted verbal de-escalation, along with other distraction techniques, tailored to each patient. We saw a good example of this occur during inspection, when a patient appeared to escalate in verbal and physical aggression. Staff responded quickly and encouraged the patient to walk towards a different area of the ward with staff. This was effective in calming the patient, and demonstrated that the staff knew the patient well.
- A 'Rapid Tranquillisation' policy was available to provide guidance to staff to treat patients for extreme episodes of agitation. These medicines were to be given only when other calming techniques had failed to work.
- Staff were aware of how to monitor patients who had received rapid tranquillisation, in line with the National Institute of Health and Clinical Excellence guidelines. Specific forms to record observations were available from the pharmacy service.
- The ward reported 83 incidents of seclusion over the six months prior to inspection. This was a reduction since the previous inspection in January 2018, where there had been 99 episodes of seclusion over the six months prior to that inspection.
- The service had reported no incidents of long-term segregation during this time.
- We examined two records of seclusion. Both records stated what led to the seclusion, time commenced and ended. Staff had completed the observations. Nursing staff undertook reviews two hourly as expected. However, on both sets of records, staff did not record what the patient took into the seclusion room, and medical reviews had not taken place four hourly, in line with policy. The provider had recently implemented an audit of seclusion practices in order to improve compliance with the Mental Health Act code of practice.
- Safeguarding training was mandatory. All staff had completed this. Staff were aware of what constituted a safeguarding referral and could explain the process of reporting.
- There was good medications management in place. Medicines were stored securely. Staff monitored the temperature of the clinic and the fridge to ensure the temperature did not affect the medications. Staff completed regular audits of the clinic room.

Acute wards for adults of working age and psychiatric intensive care units

Good

- The service had safe procedures in place for any children who visited. Staff undertook appropriate risk assessments. Staff facilitated visits in a designated room off the ward. Staff encouraged patients to meet family in the community if they had permitted leave.

Track record on safety

- We reviewed the provider's incident database. As of 28 March 2018 there were 360 incidents awaiting review, of which 263 were overdue.
- The provider has been working with NHS England to review their reporting of serious incidents. The provider told us that they over report serious incidents. The provider has recently implemented an internal serious incident review group. This group meets once a month and reviews all serious incidents reported in the last month. The group will agree if the incident is a serious incident or if it needs to be downgraded. The learning lessons group has merged with the serious incident review group. The review group also set terms of reference for any investigations.
- The ward reported four significant incidents between July 2017 and January 2018. Two of these were around concerns with restraint; one was in relation to physical health, and the fourth was in relation to an attempted absconding.

Reporting incidents and learning from when things go wrong

- All staff knew what constituted an incident and could explain the reporting process and escalation of concerns. Staff reported incidents appropriately, and in line with policy.
- The provider had an 'open and honest care' policy. The policy included links to the Health and Social Care Act regulations. A Duty of candour observation group met monthly to review all notifiable safety incidents and checked that staff had taken action in line with Duty of candour requirements. Staff said that they would be open and transparent with patients and relatives, if things went wrong. The service had updated the incident form, to include the requirement of the Duty of candour. This prompted staff to have discussions with the patient, and flagged the potential need to write a letter, in line with service policy.
- Feedback from any investigations of incidents were fed back to ward managers, who cascaded information to the ward team. When a significant incident occurred within the organisation, staff received "red top alerts" via email. These were cascaded if it was felt there was an urgent matter of learning from an incident. The organisation also produced a learning lessons flyer, which was cascaded to staff about other learning from incidents.
- Incidents at ward level were discussed daily in hand-over meetings, in team meetings; multidisciplinary meetings; supervision and where possible after an incident had occurred. Staff reported that de-briefs were offered, along with support following incidents. However, this was not always immediately following the event, due to being busy on the ward.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We examined eight care records. Staff had completed comprehensive and timely assessments of patients following admission.
- Medical staff undertook a physical health care examination of all new admissions at the earliest opportunity. Staff observed and monitored patients who had known physical health conditions. For example, we saw a care plan for a patient who was diabetic. The plan included monitoring of blood sugars and frequency, communications with the dietician and the physical healthcare team. We also saw care plans in relation to swallowing difficulties, with recommendations from the speech and language therapist.
- Care records were up to date, personalised, and holistic. Care plans were focused on recovery and discharge from the ward.
- The majority of patient information was stored electronically. All staff had access to the system. Therefore, information about patients was readily available.

Best practice in treatment and care

Acute wards for adults of working age and psychiatric intensive care units

Good

- Staff followed the National Institute of Health and Care Excellence (NICE) guidance when prescribing medications. Doctors prescribed antipsychotic medication in line with recommended limits and routine monitoring of patients was in place.
- At the time of inspection, the ward did not have a psychologist in post. However, a psychology assistant was part of the multi-disciplinary team. Staff explained that a psychologist could be requested if required for individual patients.
- The ward had access to physical healthcare. Aside from the ward team, the service had an established and accessible "physical healthcare team" on site. Staff informed this team of all new admissions, who attempted a full physical health screen of the patient. Staff then made referrals to other health care professionals, when needed, following a discussion with the multi-disciplinary team. The physical healthcare team also responded to minor illnesses and injuries, as well as urgent medical emergencies.
- The service used nationally recognised rating scales to assess and record severity and outcomes. One example was the Health of the Nation Outcome Scale. Staff used this tool to measure the health and social functioning of patients.
- The provider had implemented a new system for audits. Work was in progress to improve processes to give greater assurance. Audits were linked to compliance and legislation. Nurses participated in clinical audits, to include consent to treatment; clinic room, infection control, one to one time with patients, care plan audits and controlled drugs audits.

Skilled staff to deliver care

- The service had a full range of mental health disciplines and workers who provided input to patient care. This included doctors, nurses, healthcare assistants, social worker, activity co-ordinator, psychology assistant, and pharmacist.
- Staff employed by the service had a variety of skills, knowledge, and training.
- New staff received a corporate induction to the hospital, which included various mandatory training. Staff then spent some time on the ward allocated to familiarise with the patients and the staff group before being included as part of the ward staffing numbers.
- Staff received regular clinical and management supervision. The organisation's target for clinical supervision was 85%. Staff on Heygate ward had achieved 96%.
- The provider had introduced a new management supervision policy in November 2017. The service reported an overall rate of 93% for management supervision from 1 November 2017 to 30 March 2018. In March, the overall rate was 100%.
- All staff had received an annual appraisal, which enabled them to review the year and look at future learning and developmental needs.
- Staff received the necessary specialist training for their role. Examples of this included aspects of physical health, such as electrocardiograms, and different therapies, such as dialectical behavioural therapy.
- Managers addressed poor staff performance effectively, with support from more senior staff and advice from the human resources department.

Multi-disciplinary and inter-agency team work

- The ward held regular, weekly multi-disciplinary meetings, with good attendance from the team. During the meeting, staff reviewed and updated patient care plans.
- The ward had a nursing hand-over period, during which staff discussed all patients, risks, and progress. The ward also held a daily multi-disciplinary meeting, whereby the team reviewed each patient's progress.
- Ward staff had developed effective working relationships with external teams and commissioners.

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

- Mental health papers were examined by competent staff members upon patients' admission to ensure they were correct.
- Staff knew who their Mental Health Act administrators were and knew how to contact them for advice as and when required. The administrators ensured that the Mental Health Act was followed in relation to renewals of detention; consent to treatment and appeals against detention. Administrative support and legal advice on implementation of the Mental Health Act and its code of practice was available to staff.

Acute wards for adults of working age and psychiatric intensive care units

Good

- The service kept clear records of leave granted to patients. These included number and gender of escorts, any restrictions, the date and duration of leave, and the parameters of leave.
- At the time of inspection, all staff had completed training in the Mental Health Act. This training was mandatory. Staff interviewed had a good understanding of the Mental Health Act, the code of practice and the guiding principles.
- Staff adhered to consent to treatment and capacity requirements. Staff assessed consent to treatment as part of the admission process, and this was re-visited regularly. The ward held paper copies of consent to treatment forms, as well as having these electronically.
- Staff regularly explained patients' rights to them in relation to detention under the Mental Health Act. Nurses recorded this within each individual patient record.
- Detention paperwork was filled in correctly, was up to date and appropriately stored.
- Ward staff received emails from the Mental Health Act administrators to ensure that documentation was up to date.
- Patients had access to advocacy services. Staff were clear in their role to help facilitate this. Staff had displayed information of the ward notice boards around the rights of patients, with contact details for advocacy. We saw that some patients had received assistance from advocacy, for example in attending a mental health tribunal.

Good practice in applying the Mental Capacity Act

- Training in the Mental Capacity Act was mandatory. At the time of inspection, all staff had completed this training.
- The ward had not made any Deprivation of Liberty Safeguards applications in the last six months.
- Staff had a good understanding about the principles of the Mental Capacity Act. Staff assumed patients had the capacity to make decisions for themselves, and encouraged this. If staff felt that a patient lacked capacity around a particular issue, staff completed a capacity assessment and recorded this. We saw two examples of this. One was in relation to a physical health issue, and another was around capacity concerning managing finances independently.
- The service had a policy on the Mental Capacity Act, including Deprivation of Liberty safeguards, which staff were aware of, and could refer to, if required.
- Staff knew who to seek advice from in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The Mental Health Act administrator was available for advice around the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff usually discussed any initial concerns with the social worker and the multi-disciplinary team.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, dignity, respect and support

- We observed some good interactions between patients and staff during inspection. Staff attitudes were positive, responsive, and respectful.
- Patients told us that most staff were kind and caring towards them. One patient had raised a concern about one particular staff member. The ward manager had effectively addressed this particular concern.
- Staff had a good knowledge of the individual needs of patients, and demonstrated that they knew how best to communicate with them.

The involvement of people in the care they receive

- Staff orientated all new admissions to the ward area; introduced the patient to staff and other patients, and offered an information pack, which gave them information about the ward and of their rights.
- Four out of five patients told us that they did not attend their own multi-disciplinary meeting to discuss their care and treatment. One patient stated that they could attend if they put in a specific request. Two staff members confirmed this. However, we were advised that the psychiatric intensive care unit uses a model whereby staff discuss patients care and treatment in weekly one to one sessions.
- Nursing staff discussed care and treatment with patients during one to one time. Patients could have a copy of their care plans if they wanted. Upon admission, nursing

Acute wards for adults of working age and psychiatric intensive care units

Good

staff implemented a standardised care plan for each patient. More individualised care plans were developed, tailored to individual need, as the staff got to know the patient.

- Patients could contact the advocacy service directly via telephone, or staff contacted on their behalf. Staff referred every new admission to the advocacy service, and a visit requested to see if the advocacy could assist the patient in any way. This had become a standard procedure.
- Carers had access to a support group. The provider invited carers to informal gatherings, for example, garden parties. There was a patient and carer's lead. The provider was planning to open a carer's hub in May 2018. Staff encouraged involvement from families and carers where appropriate. Staff helped to arrange visits for those who had to travel some distance. Staff facilitated regular phone calls, to enable an update on progress.
- The ward held community meetings weekly, which all patients were encouraged to attend. This gave patients an opportunity to discuss any concerns or ideas about the ward.
- The provider completed an annual patient experience survey. This was distributed via wards. Patients were encouraged to feedback via an opinion site on the internet.
- The Men's service had a patient group, chaired by a patient. This group reviewed patient feedback and complaints to pick up any themes. One theme identified was that some patients had not had a care review for over a year. The group took action to address this, which included contacting commissioners. A patient led group was involved in auditing care plans. A patient sits on the reducing restrictive practice group. Patients sit on the panels for recruitment and there is a patient panel at staff inductions.
- Each patient care plan had a separate part to record any known advance decisions the patient may have.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- The provider reported that the average bed occupancy over the last six months prior to inspection was 28 days.
- The service accepted referrals from all over the country, mostly from acute admission wards, other psychiatric intensive care units, and from prisons.
- Patients always had access to their bed upon return from leave.
- Staff had not transferred patients between wards during an admission episode for non-clinical reasons.
- The ward had a dedicated referral line, which was in operation 24 hours. Due to the nature of the ward, referrals did occur out of office hours, and inevitably, some admissions would occur during the night. Where possible, staff planned admissions and discharges for an appropriate time of day.
- The ward reported one delayed discharge at the time of inspection. Following a review of the patient's record, it was evident that the staff had been proactively following up discharge. The patient had been on the psychiatric intensive care unit for approximately 18 months. The patient was awaiting an allocated bed elsewhere to become available. In a second patient record, we saw that staff identified that the patient no longer required a psychiatric intensive care bed. Staff had contacted the patient's home team on numerous occasions in an attempt to transfer to a more suitable environment.

The facilities promote recovery, comfort and dignity and confidentiality

- The ward had a range of rooms and equipment to support treatment and care. This included a communal day area, dining area, a games room, computer access, a quiet lounge, a meeting room, and a fitness room.
- At the time of inspection, the telephone in the private booth for patients to use was out of order. However, patients were able to make telephone calls either in private, using a hand held ward phone, or with their own mobile telephones (where permitted).

Acute wards for adults of working age and psychiatric intensive care units

Good

- The ward had direct access to outside space leading from the fitness room. The courtyard was spacious enough to enable patients to play table tennis, or have a game of football. There were benches for patients to sit on.
- The food menus varied in choice. Patients did not raise any specific concerns around the quality of the food during our inspection.
- Patients could access cold drinks freely throughout the day and night. The ward had a water-dispensing machine. Patients could have hot drinks and snacks when they wanted, but did have to ask staff for these.
- Patients were able to personalise their bedrooms if they wanted with personal effects such as photographs.
- The ward had a designated area to enable the safe storage of patient belongings.
- Patients had access to activities throughout the seven day period. A sessional timetable specific to the ward was displayed. Most sessions were recreational in nature, to include football, use of the gym or swimming pool or other activities at the sports hall. We also saw that there had been some drug awareness sessions and mental health education sessions available at times. Staff encouraged the patients to complete their own laundry, and offered some cookery sessions.

Meeting the needs of all people who use the service

- The ward did not have any patients who required disabled access during the inspection. Ward staff requested information relating to any physical disabilities as part of the referral process, to ensure that staff could meet individual needs. The ward was spacious and could facilitate those who may require disabled access.
- The service had access to various information leaflets, available in different languages for patients who were not fluent in English. This included information on how to make a complaint, and information about treatment.
- The ward had information boards for patients which included how to access advocacy, how to make a complaint, rights under the Mental Health Act, different activities and menu choices.
- The ward had access to interpreters and signers, and had utilised the translator services during an admission process for a patient who did not speak English.
- The menus had a wide range of foods, such as vegetarian options and Halal meat, to meet different dietary requirements of religious and ethnic groups.
- Staff ensured that patients had access to appropriate spiritual support. They had a visiting chaplain, and staff facilitated visits to places of worship when possible.

Listening to and learning from concerns and complaints

- There had been a two complaints between January 2017 and December 2017 related to the ward. One was in relation to methods of restraint, and this complaint was upheld. One further complaint received was in relation to communication with carers. The investigation was ongoing at time of inspection. No complaints had been referred to the Ombudsman.
- Patients we spoke with were aware of how to make complaints.
- All staff were familiar with the complaints process and were encouraged to log all complaints in line with policy.
- Staff discussed feedback from complaints during team meetings.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Vision and values

- The overarching vision of the provider was to transform lives. Values included compassion, accountability, respect, and excellence. Staff knew the values and the vision of the provider. Staff demonstrated values during interactions with patients and with other members of staff.
- Staff had an awareness of who the senior managers in the organisation were. New staff were introduced to senior management team members as part of the induction process.

Good governance

- Ward managers used key performance indicators and other tools, which enabled them to monitor the performance of the staff team.
- Staff received mandatory training. Compliance rates mostly met the providers' target of 95%.

Acute wards for adults of working age and psychiatric intensive care units

Good

- Staff received regular supervision and annual appraisals.
- A sufficient number of staff, of the right grades and experience, covered shifts. Shifts were co-ordinated around the patient needs. This demonstrated staff time on direct care activities.
- Staff participated in clinical audits, and ward managers received emails when audits were due.
- Learning was shared from incidents, complaints, and patient feedback.
- Staff followed safeguarding procedures, Mental Health Act, and Mental Capacity Act requirements.
- The ward manager had sufficient authority to undertake the role. Some administrative assistance was given through an administrator, who covered two wards.
- Ward managers had the opportunity to discuss risks in relation to the hospital risk register at governance meetings.

Leadership, morale and staff engagement

- The organisations last staff survey was circulated in 2017, with 64% of staff engaging in this. The survey demonstrated that staff were happier working for the organisation compared with the 2016 survey.
- The ward had a permanent staff sickness rate of 6%. One staff member had been off on long term sickness, but had just returned to the ward, with support from senior staff.
- There were no known bullying or harassment cases at the time of inspection.
- Staff knew how to use the whistle blowing process, and felt able to raise concerns without the fear of victimisation. Staff were also aware of the 'safe call' telephone line, which they could ring anonymously. We reviewed six whistle blowing cases from May 2017 to February 2018. Of these, two were upheld, three were partially upheld and one was on going. All of the concerns raised in these cases came through the providers 'safe call' system. This is a confidential telephone and email system provided by an independent organisation for staff. Managers had investigated all whistle blowing cases within required timeframes.
- Staff reported that they enjoyed their roles and had job satisfaction. Staff reported that morale had improved over the past few months.
- Staff of different grades had the opportunity for leadership development. Advanced clinical practice modules were available via a local university. There were leadership development opportunities, including accredited training for new and aspiring managers, full leadership programmes for nurse managers and operational leads and training for senior clinicians to become approved clinicians.
- The staff team reported that they worked well together, with mutual support.
- Staff informed the patients if things went wrong.
- Senior staff reported that they were given opportunity to give feedback on services. Other, junior staff told us that they were informed of changes, as opposed to being involved in changes. One example of this was the taking away of catering staff. This meant that a healthcare assistant had to serve meals and clean the kitchen. Senior managers told us that they had not considered the impact of changes to staff's roles and had not communicated effectively with staff. The provider shared an email they had sent to all staff apologising for this.

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- Staff observed areas of the ward that were not in direct lines of sight as part of routine ward observations. There was closed circuit television in areas such as the bedroom corridors where there were blind spots, in order to observe patients and review any incidents.
- Each ward had an up to date ligature risk assessment and environmental risk assessment However, managers had not identified the secret garden shared by Fairbairn and Prichard wards on the ligature risk assessment. On Fairbairn ward, managers had not identified the television and games console cables on the ligature risk assessment.
- Each ward had a fully equipped clinic room with access to resuscitation equipment. The resuscitation bags were kept on Robinson and Fairbairn wards and were available via emergency alert and radio to Prichard ward, which did not have its own resuscitation bag.
- All wards had seclusion rooms. We conducted a review of seclusion the week prior to inspection. The seclusion room on Fairbairn ward had a blind spot in the en suite area. At this inspection, we saw that the manager had ensured the closed circuit television camera had been adjusted to rectify this. Robinson ward had two seclusion rooms one of which was not in use due to there being a blind spot in the en suite of seclusion room 2. The extra care suite on Prichard ward had a sharp door fitting on the door to the living area on which patients may harm themselves. The provider advised after the inspection that they had taken action to rectify this.
- The majority of ward areas were clean and well maintained on all three wards. However, the therapeutic kitchen on Prichard ward was dirty with paint flaking from the windowsill, the laminate coating had come off the worktop and there was perishing food in the fridge. This posed an infection control and food hygiene risks to patients. The toilet on the bedroom corridor on Prichard ward had a leak under the sink and the laminate floor was stained. We raised this with the provider during inspection and when we visited the ward the following day we found the kitchen had been cleaned and the worktop and flaking paint and leak in the toilet had been reported to the estates department for repair.
- The provider had undertaken a full internal audit of infection control following the last inspection. This led to the introduction of an infection control assurance process, which includes unannounced reviews and spot checks. There was clear signage reminding staff to adhere to infection control principles including handwashing.
- Equipment was well maintained with stickers evidencing appliance testing had been completed.
- The majority of wards had up to date cleaning records, however, there was no cleaning schedule for the large kitchen on Fairbairn ward.
- Staff had access to appropriate alarms and radios to call for help in the event of emergency. We observed the alarms to be working during inspection with a rapid response from staff attending incidents.

- Patients had access to nurse call systems to summon help when required.

Safe staffing

- The provider had recently undergone a review of staffing using a recognised safer staffing tool and were in the process of adjusting their staffing to this.
- For the period from 1 October 2017 to 31 December 2017 Fairbairn ward used the highest number of bank staff with 415 shifts being covered by bank staff. Fairbairn covered 73 shifts with agency staff during the same period with 85 shifts unfulfilled. Since this time, this ward has benefitted from two new qualified staff. Robinson ward used bank staff for 215 shifts, agency staff for 65 shifts and had 64 unfulfilled shifts over the same period. Prichard ward had 148 shifts filled by bank staff, 117 shifts filled by agency staff and had 59 unfulfilled shifts due to sickness absence or vacancies.
- Staffing establishment levels for permanent staff on Robinson ward were 12 full time registered nurses and 16.5 full time health care assistants. They had three vacancies for registered nurses and no vacancies for healthcare assistants.
- On Fairbairn ward, the establishment was 10 full time registered nurses and 16.5 full time health care assistants. They had two vacancies for registered nurses and no vacancies for healthcare assistants.
- On Prichard ward, the establishment was 10 full time registered nurses and 18.5 full time health care assistants. They had one vacancy for a registered nurse and no vacancies for healthcare assistants.
- When bank and agency staff were used they were primarily sourced through the provider's bank bureau, agency staff were used as a last resort. Managers tried to use bank staff that were familiar with their ward.
- All three ward managers were able to adjust the staffing levels to take account of case mix. We saw examples of shifts where staffing had been increased to take account of patients who required increased observation.
- Qualified nurses were available in communal areas of the ward at all times.
- Staff and patients told us that patients did not always receive their weekly one to one time with their named nurse. This was particularly evident on Robinson ward although data shown to us during inspection was conflicting, meaning that it was difficult to ascertain how often this happened.
- Patient leave was often rearranged due to low staffing levels or high patient acuity on the ward. However, managers ensured that leave was honoured at the earliest opportunity.
- Doctors operated a two tier on call rota for medical cover during the day and night. Staff we spoke with said the on call doctor was able to reach the wards within 10 minutes. We reviewed the medical first on call and twilight on call logs for the whole Northampton site (four locations) from 2 September 2017 to 19 March 2018. A total of 5,388 hours of medical on call cover was provided over this period. The on call doctors completed 3,186 tasks within these hours, equating to an average of 0.6 tasks per hour. Of these tasks,1,318 (23%) related to seclusion. Based on each seclusion task taking an average of 20-30 minutes, this equates to 549 hours (10%) of the total on call hours provided.
- Of the total tasks 694 (22%) related to the men's services. Of these 327 (47%) related to seclusion tasks, equating to 136 hours of on call time.
- Doctors advised that they were not always able to complete seclusion reviews within the timescales required by the Mental Health Act code of practice. They provided additional data relating to weekend on call cover for 30 weekend days from August 2017 to March 2018. A total of 368 tasks were provided in 88 hours. This equated to an average of four tasks per hour, of these 212 (58%) were seclusion tasks. Men's services accounted for 108 tasks, of which 73 were seclusion tasks, totalling 30 hours (34%) of on call time.
- The provider had completed a review of the hospital at night. A working group was deciding on actions to be implemented. Plans were in place to increase the provision of physical healthcare at night to relieve some of the pressure on the on call doctors.
- All three wards had made progress towards their target of 95% of staff accredited for mandatory training however, for basic life support training, Prichard ward was 71% compliant and Robinson ward was 70% compliant. For immediate life support training Fairbairn was 71% compliant and Robinson 57% compliant. Wards had members of trained staff allocated to response teams to support emergency situations. For information governance training Fairbairn and Robinson wards were 73% compliant respectively against a target of 85%. Whilst all wards exceeded their target for separate safeguarding children and adults levels one and two, the provider had recently introduced a

combined adults and children safeguarding level three in response to feedback from our last inspection. At the time of inspection Fairbairn and Robinson wards were 29% compliant with this whilst Prichard ward was 33% compliant.

Assessing and managing risk to patients and staff

- The provider reported incidents of seclusion and restraint had increased considerably on Prichard ward since the last comprehensive inspection in May 2017 when there had been 10 episodes of seclusion and 18 restraints of which nine were prone restraint. Prone restraint is a form of restraint where the patient is held in the chest down position. During the period from 1 July 2017 to 31 December 2017, Prichard ward had 36 seclusions and 41 restraints for eight service users. Seven of these restraints were prone restraint. We spoke with the responsible clinician for this ward who told us that they had been working to improve the culture of positive behavioural support on this ward. Several changes had been made to staffing recently in the multidisciplinary team and the appointment of a new ward manager to look at least restrictive interventions.
- Robinson ward had 14 seclusions, eight restraints for five patients, five of which were in the prone position during the period from 1 July 2017 to 31 December 2017.
- Fairbairn ward had seven episodes of seclusion, five restraints for three patients, none of which were in the prone position.
- One of the episodes of prone restraint on Robinson ward was used for the purpose of administration of rapid tranquillisation medication. Staff had recently been trained in the use of alternative sites for injections.
- In the weeks prior to the inspection, the CQC conducted a review of seclusion practice across the men's service. One patient on Fairbairn ward did not have four hourly medical reviews as outlined by the Mental Health Act 1983 code of practice. For the two records reviewed on this ward neither had seclusion care plans.
- On Robinson ward, we found one seclusion record where the medical reviews had not been conducted as planned twice per day.
- Staff did not follow the provider's seclusion policy. On Prichard ward, one patient's period of seclusion lasted for 25 days. Medical reviews ranged between one to three times per day. On four days we were unable to find any documentation of a medical review taking place. We noted that the seclusion care plan stated medical reviews should happen twice daily. Nursing reviews ranged between five to 14 times during the day. A registered nurse concluded seclusion. In another patient's record we were unable to find any evidence of nursing reviews taking place during the patients eight hour period of seclusion. A different patient's seclusion record showed that the doctor did not attend the seclusion review for four hours and 15 minutes after seclusion commenced and this patient did not have a seclusion care plan. A further patient's record revealed that a multidisciplinary review had taken place with a decision to end seclusion; however the seclusion did not end for a further four hours. This patient did not have a seclusion care plan.
- The provider had recently implemented an audit of seclusion practices in order to improve compliance with the Mental Health Act code of practice.
- We reviewed 18 sets of care records; five on Fairbairn ward, six on Robinson ward, and seven on Prichard ward. All records demonstrated that staff undertook a risk assessment of every patient on admission and regularly thereafter and after every incident.
- Blanket restrictions were only used in line with contraband restrictions for medium secure services.
- The provider had policies for searching and observation of patients. However, we found that the observation policy was not always followed. The observation records charts had times of observation prepopulated so that it was difficult for staff to record the exact timings of observation. We reviewed two observation records on Prichard ward where there were gaps in the recording of observations and no rationale for the observation not being carried out. We were not assured that patients were being observed as robustly as they might have been and this could lead to incidents of self-harm or physical aggression for patients.
- All permanent and bank staff were trained in the management of actual or potential aggression. Staff told us that restraint was used only as a last resort.
- There were safe procedures for families and carers including children to visit the hospital. Children could visit following a suitable risk assessment in a designated family room near the reception, which was pleasantly decorated and equipped with toys and games.
- We observed a medication round using the electronic prescribing system. The registered nurse did not sign for each individual patient following administration of their medication and instead signed the electronic

administration record for all patients having completed the round. This meant there was a delay and could have led to errors in the signing for medication that had been given and contravened the Nursing Midwifery Council guidance on administration of medication.

Track record on safety

- We reviewed the provider's incident database. As of 28 March 2018 there were 360 incidents awaiting review, of which 263 were overdue.
- The provider has been working with NHS England to review their reporting of serious incidents. The provider told us that they over report serious incidents. The provider has recently implemented an internal serious incident review group. This group meets once a month and reviews all serious incidents reported in the last month. The group will agree if the incident is a serious incident or if it needs to be downgraded. The learning lessons group has merged with the serious incident review group. The review group also set terms of reference for any investigations.
- The provider reported 52 serious incidents for all the wards in the men's pathway. Prichard ward was the highest reporting ward with 11 serious incidents and Fairbairn ward had 10.
- The most common incidents were allegations of abuse against staff and patient on patient violence and aggression. The provider recognised that previous methods used to manage violence and aggression had been too restrictive. Consequently, the provider had retrained staff in the management of actual or potential aggression and there is now an increased emphasis on de-escalation and least restrictive practice.
- The provider had improved its governance process for managing serious incidents and disseminating learning from them. Managers said they attended weekly governance meetings. However, there was little documentation of the outcome of these meetings.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew what incidents to report and how to report them. We were assured that all incidents that should be reported were reported. The provider notified CQC of relevant incidents.
- The provider had an 'open and honest care' policy. The policy included links to the Health and Social Care Act regulations. A Duty of candour observation group met monthly to review all notifiable safety incidents and checked that staff had taken action in line with Duty of candour requirements. Staff were open and transparent and would explain to patients and carers when things went wrong. The provider had developed a "knowledge nugget" within their electronic recording system for the recording of serious incidents to outline the Duty of candour responsibilities to staff.
- Staff we spoke with told us that they received feedback from investigation of serious incidents through supervision and staff meetings. There was evidence that reflective practice sessions were in progress during our inspection. There was evidence in care plans of changes having been made as a result of feedback. However, there was little evidence of the recording of feedback in team meeting minutes or on the incident action plan.
- Staff we spoke with said they received debriefs following serious incidents and felt well supported by their manager and the team.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed 18 care records for this core service, all displayed timely assessments completed after admission.
- Care records were comprehensive and showed that physical examination had been undertaken and that there was ongoing monitoring of physical health problems. However, two care plans on Robinson ward lacked detail about the specific methods of implementation required. We raised this with the provider during inspection and the ward manager immediately updated the care plans to a good standard, making it clear how staff should carry out the plan.
- Care plans were regularly updated, personalised, holistic and recovery orientated.
- All information needed to deliver care was stored electronically and was available to staff when they needed it. There were also paper based copies of positive behavioural support plans available in each ward office.

Requires improvement

Forensic inpatient/secure wards

Best practice in treatment and care

- There was evidence that staff followed the National Institute for Health and Care Excellence guidance when prescribing medication.
- Each ward had access to a psychologist and assistant psychologist who delivered the recommended psychological therapies including index offence related therapy and dialectical behaviour therapy.
- The provider had an onsite physical healthcare team including practice nurses. Staff were proactive in referring patients to the local general hospital when required.
- We saw evidence that staff assessed and met service user's nutrition and hydration needs. However, we found that staff had not always completed food and fluid balance charts for a patient with diabetes on Prichard ward.
- Staff used recognised rating scales to assess and record severity and outcomes including the Health of the Nation Outcome Scales. Robinson ward was a centre of excellence for the use of the Vona du Toit Model of Creative Ability. This was an occupational therapy practice model that focused on recovery and ability.
- Staff we spoke with told us they were involved in audits of care plans and patient records and the provider submitted the audit programme to us during inspection.
- The provider had implemented a new system for audits. Work was in progress to improve processes to give greater assurance. Audits were linked to compliance and legislation.

Skilled staff to deliver care

- The multidisciplinary team included the full range of mental health disciplines expected to provide care to this patient group and included occupational therapists, psychologists, social workers, nurses, health care assistants, activities coordinators, activity nurses, pharmacists. However, staff we spoke with said that there had been a reduction in the number of social workers and occupational therapists available to this service meaning that social workers were now providing support to more than one ward. This meant that social workers only had time to focus on their statutory responsibilities and had little time to support patients with family work.
- Patients said they had less access to occupational therapy sessions. Several band five occupational therapists had left this service recently and had not been replaced. The provider had recruited several band four activity nurses but there was a concern that there were not enough professional occupational therapists to inform occupational therapy.
- There was a suitable mix of experienced and newly qualified staff, and staff told us they were supported to attend specialised training specific to their role.
- Staff we spoke with, who were new to the service, told us they received a comprehensive induction.
- The provider's target for staff to receive clinical supervision during the period from 1 January 2017 to 31 December 2017 was 85%. The actual supervision rates were 84% on Fairbairn ward, 67% on Prichard ward and 70% on Robinson ward. The service reported an overall rate of 65% for management supervision from 1 November 2017 to 30 March 2018. In March the overall rate was 97%.
- 100% of medical and non-medical staff from all three wards had received an appraisal in the last 12 months.
- Staff we spoke with said they had good access to training for their role and the provider had a programme for training healthcare assistants to become registered nurses.
- Staff performance was addressed promptly and effectively. The ward manager gave examples of recent incidents which had led to disciplinary proceedings for staff.

Multi-disciplinary and inter-agency team work

- During our inspection we observed three handover meetings and one ward round. We observed that staff on all wards appeared to have a comprehensive knowledge of patients' needs. Staff spoke about patients in a caring manner and had a recovery focus to the discussion.
- There were handovers at the beginning of each shift and a multidisciplinary handover each day at 9.00am. We saw staff documented handovers in a paper record to ensure that staff joining the ward at a later time had access to the most recent information.
- We saw evidence in care records that staff communicated effectively with teams outside of the organisation, for example if patients attended the general hospital.

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

Requires improvement

Forensic inpatient/secure wards

- A competent member of staff examined patients Mental Health Act papers on admission to the hospital.
- Staff said they knew who the Mental Health Act administrators were and could access their support when needed.
- Each ward kept a clear record of the leave each patient was entitled to. Each patient had a robust care plan about their leave including risks and crisis contingency measures. Patients had paper copies of their leave entitlement and for deaf patients these had been written in pictorial form.
- 76% of staff on Fairbairn ward, 97% of staff on Prichard ward and 100% of staff on Robinson ward had received training on the Mental Health Act. Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and guiding principles.
- We saw evidence that all prescriptions were accompanied by the correct consent to treatment forms and there was evidence in care records that capacity requirements had been assessed and documented.
- There was evidence in care records that patients had their rights under the Mental Health Act explained to them regularly. Patients had been given leaflets explaining their rights and for deaf patients on Fairbairn ward these had been given in sign language and pictorial form.
- The detention paperwork we reviewed had been filled in correctly, was stored appropriately and copies were scanned onto the electronic recording system.
- There were posters on each ward giving patient's information on how they could contact an independent mental health advocate. Patients told us that they had accessed advocates easily in the past and that an advocate regularly attended the wards.
- There were regular audits to ensure the Mental Health Act was being applied correctly. The provider had recently introduced an audit of seclusion which had identified the issues we found on inspection.
- However, we found that medical reviews of patients detained in seclusion were not always happening in a timely manner, and some seclusion care plans had not been filled out correctly.

Good practice in applying the Mental Capacity Act

- Staff were trained in and had a good understanding of the Mental Capacity Act (2005).
- The provider had a Mental Capacity Act policy and deprivation of liberty safeguards available online that staff were familiar with and could refer to.
- For people who had impaired capacity, capacity to consent was assessed and recorded appropriately on a decision specific basis with regard to significant decisions. We saw evidence in care records that patients were given every possible assistance to make a decision themselves before they were assumed to lack mental capacity to make it.
- We saw evidence in care records that when patients lacked capacity they were supported to make decisions in their best interests, recognising the importance of their wishes and feelings, culture and history.
- Staff knew where to get advice regarding the Mental Capacity Act. There were no informal patients on the wards we visited so Deprivation of Liberty Safeguards did not apply.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- We observed that the majority of staff acted in a respectful and caring manner when interacting with patients. Two members of the inspection team observed one member of staff was rather abrupt with a patient who had requested the remote control to change the channel on the television on Fairbairn ward. Their communication style was not supportive of a person with a hearing impairment.
- Most patients we spoke with on all three wards told us that they felt safe. Patients said they felt relaxed and that staff were competent in their roles, and were caring and approachable. However, one patient on Robinson ward told us he felt that staff bullied patients and that he was less likely to get his leave when a certain shift was working.
- We spoke with three carers, all of whom said they felt assured that their relatives were safe, and one praised the service saying their son was the best he has been since being on Prichard ward and there are plans for him to move on.

Requires improvement

Forensic inpatient/secure wards

- One carer expressed concern at staffing levels on Prichard ward and said that their relative did not often receive the full twice weekly psychology session planned for them; they had one 30 minute session. They were also concerned that there was no longer a full time social worker for this ward as this had resulted in less opportunity for family work.

The involvement of people in the care they receive

- The admission process informed patients about their care and orientated them to the wards and the service.
- Patients were actively encouraged to be involved in their care plans and take part in their ward round and were offered a copy of their care plan.
- An independent advocate attended the wards on a weekly basis and could be accessed as required.
- Carers we spoke with felt that they were appropriately involved in their relative's care. Carers had access to a support group. The provider invited carers to informal gatherings, for example, garden parties. The provider employed a patient and carer's lead. The provider was planning to open a carer's hub in May 2018.
- Patients we spoke with knew how to complain. We saw evidence in community meeting minutes that patients could give feedback on the development of the service.
- The provider completed an annual patient experience survey. This was distributed via wards. Patients were encouraged to feedback via an opinion site on the internet. The men's service had a patient group, chaired by a patient. This group reviewed patient feedback and complaints to pick up any themes. One theme identified was that some patients had not had a care review for over a year. The group took action to address this, which included contacting commissioners. Another patient led group was involved in auditing care plans. A patient sits on the reducing restrictive practice group. Patients sit on the panels for recruitment and there is a patient panel at staff inductions.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- The average bed occupancy over the period from 1 July 2017 to 31 December 2017 was 100% for Fairbairn ward, 93% for Prichard ward and 99% for Robinson ward.
- Over the period 1 January 2017 to 31 December 2017 the average length of stay was 347 days on Fairbairn ward, 238 days on Robinson ward and 183 days on Prichard ward.
- It was rare for patients to have overnight leave from these wards but when they did a bed was always available for them on their return.
- Patients were not moved between wards during their admission unless this was justified in their best interest. When patients were moved or discharged this happened at an appropriate time of day.
- There was access to enhanced support suites within the hospital for patients should they require a more intensive period of care.
- Reasons for delayed discharges included lack of appropriate low secure beds or community facilities, and delays in funding for future placements.
- The provider reported that from the period from 1 July 2017 to 31 December 2017 there had been two delayed discharges and both of these patients were cared for on Robinson ward. The provider told us that this was due to a lack of suitable placement.
- We saw that care plans referred to identified section 117 aftercare services for patients who had been subject to section 3 or the equivalent forensic section of the Mental Health Act.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had a full range of rooms to provide treatment and care. Each ward had a clinic room therapy kitchen and activities room. Robinson ward had a well-resourced therapy room.
- There was a quiet area near the hospital reception where patients could meet with visitors. There were also meeting rooms just outside the ward area that visitors could use.
- Each ward had an area where patients could make telephone calls in private, although these were positioned near to the television on Prichard ward. We observed one patient asking to have the television turned down so that he could hear to take the call. Deaf patients on Fairbairn were able to access video conferencing to speak with carers and professionals with the aid of an interpreter.

Requires improvement

Forensic inpatient/secure wards

- Each ward had access to outside space. The areas were locked but were opened for patients on request. We were told in good weather the door was often left open for patients to access freely. There was a "secret garden" area shared between Prichard and Fairbairn ward but this was not currently in use, due to damage caused during a recent incident.
- Patients told us the food was of good quality and they could choose from a four weekly menu. Food choices included halal, kosha and vegetarian meals.
- Patients were not allowed to make hot drinks and snacks, following the outcome of a risk assessment. Staff provided these at designated times throughout the day and in response to individual requests at other times.
- Patients were able to personalise their bedrooms and had ample space to store permitted personal possessions.
- Each ward had an activities coordinator and there was access to activities throughout the week and at weekends. Patients on Prichard ward told us they had a movie and popcorn night the evening prior to our visit. On all wards, there was a visible timetable of activities on the ward notice board. We observed patients having a curling session and accessing the hospital patient café. We also observed patients accessing "light and heavy industry work" in the provider's woodwork department.

Meeting the needs of all people who use the service

- There were accessible bathrooms and toilet facilities on each ward for patients who required disabled access.
- There were information leaflets available on treatments, how to make a complaint, the Mental Health Act and patient's rights, and advocacy in the main hospital reception. Staff told us these were available in other languages upon request. We saw that for deaf patients information was available in alternative formats including DVDs.
- There was easy access to interpreters for those for whom English was not their first language. On Fairbairn ward most staff were competent in British sign language or were undergoing training. There was a 50% mix of deaf and hearing staff in an effort to promote the deaf culture.
- Patients had access to appropriate religious and spiritual support, there was a multi-faith room within the hospital and patients were provided with a suitable quiet space on the ward to pray. Staff gave examples of times that they had supported patients to access religious centres in the patient's local community. There was also a list of contact details for local religious and spiritual leaders available on the patient notice boards.

Listening to and learning from concerns and complaints

- The provider submitted information that forensic secure wards received 15 complaints between 1 January 2017 and 31 December 2017, of these nine were about Prichard ward. Two of these were upheld, two partially upheld and five were under ongoing investigation. Fairbairn ward received five complaints four of which were upheld and one was withdrawn. Robinson ward had received one complaint which was under investigation. No complaints had been referred to the ombudsman.
- Patients we spoke with knew how to complain and said that the majority of their concerns were addressed directly by staff.
- Staff knew how to handle complaints appropriately. Managers told us that they resolved the majority of complaints on the wards but occasionally complaints were passed to the complaints department.
- Staff told us they received feedback on the outcome of investigation of complaints either through staff supervision or team meetings. This was evident in meeting minutes on Robinson and Fairbairn wards. On Prichard ward however, staff had not had a team meeting since December 2017.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

- Staff we spoke with knew and agreed with the organisation's vision "to transform lives" and the values through which they hope to achieve the vision are compassion, accountability, respect and excellence.
- The team objectives reflected the organisations vision and values.

Requires improvement

Forensic inpatient/secure wards

- Staff we spoke with knew who the most senior managers in the organisation were but did not feel valued by senior managers. Staff said senior managers rarely visited the wards.

Good governance

- Governance processes had improved since the inspection in May 2017, although we found a high number of incidents were overdue a review.
- Managers ensured staff were up to date with mandatory training, staff were below the expected level for basic life support, immediate life support and level three safeguarding training.
- Whilst they had made considerable progress with embedding the importance of regular clinical and managerial supervision, managers had not met their target for clinical supervision. The most recent data, from March 2018, for management supervision evidenced a rate of 97%.
- Managers had not ensured that there were the sufficient numbers of staff on shift to enable patients to have regular sessions with their care coordinator.
- Staff had taken on the responsibility of serving meals on the ward. Staff told us that up to six hours per shift could be spent on kitchen duties as opposed to direct care. Staff were concerned that managers had not ensured that there were extra staff available to facilitate this. Some staff were unclear exactly what their responsibilities were, however, we saw the provider had sent out information on this at the time of implementation. Senior managers told us that they had not considered the impact of changes to staff's roles and had not communicated effectively with staff. The provider shared an email they had sent to all staff apologising for this.
- Staff participated in clinical audit of care records.
- The provider used key performance indicators to measure the performance of the team, and monitored these in weekly governance meetings. Key areas included nutritional screening, completing and updating risk assessments, incident reporting, completing patient information sheets and notes audits.
- Ward managers told us they had sufficient authority and administrative support.
- Staff had the ability to submit items of concern to the provider's risk register.

Leadership, morale and staff engagement

- The 2017 staff survey conducted by the provider showed a 64% staff engagement score; of the 56 questions asked by the provider 53 showed improvements on the previous year. 88% of staff thought that the provider looked after patients with compassion, 85% were willing to give extra effort to help the provider meet their goals, and 83% of staff thought that their team constantly looked at ways to do their jobs better.
- Sickness and absence rates for this core service were 6% for Fairbairn ward, and 3% respectively for Robinson and Prichard wards.
- There were no cases of bullying or harassment reported to us by staff.
- Staff we spoke with knew how to use the whistleblowing process and said they felt they could raise concern without fear of victimisation. We reviewed six whistle blowing cases from May 2017 to February 2018. Of these, two were upheld, three were partially upheld and one was ongoing. All of the concerns raised in these cases came through the provider's 'safe call' system. This was a confidential telephone and email system provided by an independent organisation for staff. Managers investigated all whistle blowing cases within required timeframes.
- Staff said they felt supported by the ward managers and staff on Prichard ward were pleased with the recent appointment of a new ward manager.
- The provider was in the process of reconfiguring services to include integrated practice units, which would cluster services based on patient diagnosis. Staff told us there was a high level of mutual support within the team but morale had been affected by reductions in the multidisciplinary team, extra kitchen duties without replacement staff and the uncertainty of what integrated practice units will mean for the service and their roles.
- We found that career progression was encouraged. Advanced clinical practice modules were available via a local university. There were leadership development opportunities, including accredited training for new and aspiring managers, full leadership programmes for nurse managers and operational leads and training for senior clinicians to become approved clinicians.
- We received feedback from staff we spoke with that staff had been told not to be negative at transformation meetings. Staff had therefore felt they could not express their concerns about service developments.

Requires improvement

Forensic inpatient/secure wards

Commitment to quality improvement and innovation

- Robinson ward was a centre of excellence for the Vona du Toit Model of Creative Ability.
- The provider was a member of The Quality Network for Forensic Mental Health Services.

Long stay/rehabilitation mental health wards for working age adults

Good

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

Safe and clean environment

- The rehabilitation wards had blind spots impacting on lines of sight for staff to monitor patients. However, the provider had installed mirrors and positioned staff in corridor areas to support observation of patients.
- Ligature points (places to which patients intent on self-harm might tie something to strangle themselves) had been identified as part of the monthly environmental risk assessment audit and actions had been identified to reduce the risk to patients. Staff knew where to locate ligature cutters on each ward, contained in yellow wall mounted boxes.
- Wards complied with the Department of Health's guidance for mixed sex accommodation , which meant that the privacy and dignity of patients was upheld.
- Clinic rooms were visibly clean and had enough space to prepare medications and undertake physical health observations. Physical health monitoring equipment had been calibrated and staff carried out weekly checks to ensure it was in good working order. Staff checked emergency resuscitation equipment on a daily basis.
- The provider had undertaken a full internal audit of infection control following the last inspection. This led to the introduction of an infection control assurance process, which included unannounced reviews and spot checks.
- Fenwick and Church ward had a seclusion room. On Church ward the closed circuit television monitor for the seclusion room was not working. This meant there was a blind spot. As a result, the provider had declared the room as "out of order", until the monitor was repaired. The drain in the room smelt unpleasant. This had been reported to maintenance.
- The wards were well maintained, clean and clutter free. Cleaning rotas had been completed and the wards were visibly clean and tidy.
- The kitchen fridge on each of the wards contained open items of food. Labels were not in place indicating when the food had been opened and when it should have been consumed by.
- Patients had access to call bells to summon staff help when required.

Safe staffing

- The whole time equivalent of qualified staff on Ashby ward was 9.6 with no posts vacant at the time of the inspection. The whole time equivalent of unqualified staff was 14 with 1.8 (13%) vacant posts at the time of the inspection. Staff sickness rates were 6%. Between 1 October 2017 and 31 December 2017, there were 276 shifts filled by bank staff, 53 shifts filled by agency staff and 33 (9%) of shifts were not filled to cover absence.
- The whole time equivalent of qualified staff on Church ward was five with no vacant posts at the time of the inspection. The whole time equivalent of unqualified staff was 8.5 with no vacant posts at the time of the inspection. Staff sickness rates were 0.6%. Between 01 October 2017 and 31 December 2017, there were 280 shifts filled by bank staff, 51 shifts filled by agency staff and 54 (14%) of shifts were not filled to cover absence.
- The whole time equivalent of qualified staff on Fenwick ward was five with no vacant posts at the time of the

inspection. The whole time equivalent of unqualified staff was 8.5 with no vacant posts at the time of the inspection. Staff sickness rate was 1%. Between 1 October 2017 and 31 December 2017, there were 294 shifts filled by bank staff, 50 shifts filled by agency staff and 40 (10%) of shifts were not filled to cover absence.

- Ward managers were able to adjust staffing levels to meet the changing needs of patients requiring high levels of monitoring linked to risks. We reviewed the staffing rota, which showed there was sufficient staff to meet the patients' clinical need.
- We saw that a qualified nurse was often in the communal areas of the wards, and a support worker was present in the communal areas at all times.
- Staff reported that escorted leave was occasionally cancelled or rearranged due to staff shortages. The staffing rotas showed there was the appropriate number of qualified nursing staff on each shift.
- Mandatory training compliance was 93% for Ashby ward, 98% for Church ward and 100% for Fenwick ward.

Assessing and managing risk to patients and staff

- There were two episodes of seclusion across the three rehabilitation wards between January and March 2018. These were on Ashby ward; we examined the seclusion records and found that the provider's seclusion documentation had been completed. However, in both records, staff had not developed seclusion care plans for patients.
- Over the same time there were eight episodes of restraint, involving three patients, one resulting in use of prone restraint and subsequent use of rapid tranquillisation. We saw staff had carried out the required physical health monitoring following the administration of rapid tranquillisation medicine.
- Staff demonstrated awareness of the clinical importance of physical health care monitoring following use of rapid tranquillisation in line with the National Institute for Health and Care Excellence guidance.
- We reviewed 18 care records. Each patient had an individualised risk assessment completed on admission. All patients had an up to date care plan. Staff used recognised risk assessment tools including Short-Term Assessment of Risk and Treatability and The Historical Clinical Risk Management used to assess risk of violence.
- There were no blanket restrictions on the wards.
- The provider had a policies for searching and observation of patients, which staff followed.
- Staff described how they would identify and make a safeguarding referral. There was 100% compliance in level one and level two safeguarding training. However, compliance for level three training was 57% on Ashby ward, 67% on Church ward and 34% on Fenwick ward. The provider had recently launched a new package of safeguarding training.
- Staff stored medicines in accordance to the manufacturers' guidelines. Staff recorded patient allergy information on the electronic medication records. There were systems in place for reporting medication administration errors.
- Staff recorded the temperature of the clinic room and refrigerator daily, to ensure the temperature did not affect the efficacy of the medication.
- There were safe procedures for families and carers including children to visit the hospital.

Track record on safety

- We reviewed the provider's incident database. As of 28 March 2018 there were 360 incidents awaiting review, of which 263 were overdue.
- The provider has been working with NHS England to review their reporting of serious incidents. The provider told us that they over report serious incidents. The provider had recently implemented an internal serious incident review group. This group meets once a month and reviews all serious incidents reported in the last month. The group will agree if the incident is a serious incident or if it needs to be downgraded. The learning lessons group has merged with the serious incident review group. The review group also set terms of reference for any investigations.
- In the 12 months prior to the inspection, Ashby ward reported five serious incidents. The nature of these related to one unauthorised absence, one medication error, one regarding missing property, one fall and one incident whilst a patient was on leave.
- In the 12 months prior to the inspection Fenwick ward reported four serious incidents. The nature of these were one unauthorised absence, one prohibited item, one device failing a safety check and an allegation of a patient feeling uncomfortable when a particular member of staff was on duty.
- There were no serious incidents reported for Church ward in the 12 months prior to inspection.

Long stay/rehabilitation mental health wards for working age adults

Good

- Staff told us they received debriefs and support following incidents or management of difficult situations.

Reporting incidents and learning from when things go wrong

- Staff demonstrated awareness of how to use the electronic recording system for reporting incidents. From patient records reviewed, where there had been an incident, records included a reference number, resulting in an audit trail.
- The provider had an 'open and honest care' policy. The policy included links to the Health and Social Care Act regulations. A Duty of candour observation group met monthly to review all notifiable safety incidents and checked that staff had taken action in line with Duty of candour requirements. Ward managers and staff demonstrated understanding of Duty of candour, and the need to ensure openness and transparency, explaining to patients where applicable when things go wrong. We saw evidence of this in ward community meeting minutes.
- Staff discussed incidents and learning points in team meetings. We saw minutes of these meetings where staff had discussed changes that needed to be made to the ward to prevent further incidents.
- Managers held formal and informal debrief meetings with staff and patients after incidents. Staff were able to access support from the provider occupational health team.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff completed comprehensive assessments for patients, which they completed in a timely manner in collaboration with the patient and their families where appropriate. We looked at 18 care plans, they were up to date, personalised, holistic, recovery orientated and included physical health checks where appropriate. However, care plans were not available in an accessible form, for example in pictorial form for those patients who did not want or were not able to understand a lengthy paper document.
- Staff monitored patient's weight, pulse, temperature, bloods and undertook ongoing neurological investigations to identify when a patient was becoming unwell.
- Staff recorded detailed objectives and individualised goals on patient care plans, which included patient's views. Staff and patients reviewed these care plans regularly.
- Patients said they knew their goals and were offered a copy of their care plan.
- Staff used an electronic system to store patients' records securely.

Best practice in treatment and care

- We reviewed 34 medication records, there was evidence that staff adhered to National Institute for Health and Care Excellence guidance when prescribing medication. Where applicable, records demonstrated completion of the Glasgow Antipsychotic Side-effect Scale. Some patients told us they had discussed their concerns regarding medication and side effects with the multi-disciplinary care teams during ward rounds and care review meetings.
- Patients accessed psychological therapies in line with the National Institute for Health and Care Excellence guidance; these included cognitive behavioural therapy, dialectical behavioural therapy and sex offender treatment programmes. There was reference made to National Institute for Health and Care Excellence guidelines for patients with positive behaviour support care plans.
- Patient records contained use of Health of the Nation Outcome Scales – Secure, to enable staff to rate clinical risks.
- The provider had implemented a new system for audits. Work was in progress to improve processes to give greater assurance. Audits were linked to compliance and legislation. The service had participated in several audits; these included physical healthcare monitoring, medication, nutritional needs, restraint and patient records.

Skilled staff to deliver care

Long stay/rehabilitation mental health wards for working age adults

Good

- The three rehabilitation wards had a full range of mental health disciplines within their multi-disciplinary teams. These included occupational therapists, social workers and psychologists working collaboratively with the doctors and nurses on the wards.
- Staff told us they received a thorough induction, and shadowing opportunities. Health care workers received training in line with the Care Certificate standards.
- Clinical supervision was variable across the wards. Compliance rates were 100% for Ashby ward, 87% for Church ward and 75% for Fenwick ward. The provider target for clinical supervision was 85%.
- The provider had introduced a new management supervision policy in November 2017. The service reported an overall rate of 62% for management supervision from 1 November 2017 to 30 March 2018. In March, the overall rate was 98%.
- Each ward had a key performance indicator dashboard for each month, which included feedback from patients, complaints, safeguarding, serious incidents, staffing and audits.
- Appraisal completion rates for qualified nurses and health care workers were 100% for all three rehabilitation wards.
- Ward managers advised they had no staff suspended or under supervision at the time of the inspection visit.

Multi-disciplinary and inter-agency team work

- The wards held regular multi-disciplinary team meetings. These meetings offered staff the opportunity to discuss clinical cases and review incidents. We reviewed meeting minutes that showed managers shared information such as, incidents and lessons learnt and ward updates.
- We attended shift handover meetings on Church and Fenwick wards. Staff completed an electronic handover sheet, which they printed and used as a source of reference in the handover. Staff could access the printed sheet throughout the next shift held in a folder in the nursing station.
- Ward managers reported improved working relationships with community mental health services and continued involvement from advocacy and local authority teams.

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

- Data provided prior to the inspection details mandatory training for the men's pathway, which includes the rehabilitation wards with completion rates for Mental Health Act training at 100%.
- Mental Health Act paperwork was scrutinised and scanned onto the provider's electronic records system by the MHA administration team. T2 and T3 paperwork in relation to consent to treatment linked to patient medication records. Paperwork was in order for the records we reviewed.
- Staff would contact the Mental Health Act administrative team if they needed any specific information about the Mental Health Act.
- Patient leave entitlement was clearly documented in their records and outcomes from leave placed in progress notes.
- Patients used multi-disciplinary meetings and community meetings to make requests for review of their leave entitlement or as a forum to make suggestions in relation to activities they wanted to participate in.
- We examined 18 records, all contained a document to indicate that patient's had their rights under the Mental Health Act explained to them, and reviewed every six months, with a reminder setting in place on the electronic records system.
- Patients had access to advocacy and independent mental health advocates for support with complaints and tribunals. Information leaflets on services including advocacy were on display in ward areas.
- Ward managers told us that the Mental Health Act administration team completed audits of Mental Health Act paperwork. This ensured patient's detention papers were in place and up to date.

Good practice in applying the Mental Capacity Act

- Data provided prior to the inspection details mandatory training for the men's service which includes the rehabilitation wards with completion rates for Mental Capacity Act training at 100%.
- For the six months prior to the inspection there had been no Deprivation of Liberty Safeguards applications or authorisations for the three rehabilitation wards.
- Staff described principles of the Act and understood their responsibilities and said they would seek advice from the Mental Health Act administrator if required.
- We saw evidence of capacity being assessed as and when appropriate. This was on a decision specific basis.

Long stay/rehabilitation mental health wards for working age adults

Good

- Patients told us they felt able to make their own decisions and staff supported them to do so.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

- Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw that staff were responsive to patient's needs and were respectful. Staff treated patients with dignity and remained interested when engaging patients in meaningful activities. Staff interacted with patients at a level that was appropriate to individual needs.
- We spoke with 11 patients who told us that they had good relationships with staff and they were very helpful, understood their problems and were always available. They said they felt safe and that staff took the time to listen to them when they had a problem.

The involvement of people in the care they receive

- Independent advocacy services were available to support patients. Advocates visited the wards regularly and patients could also request appointments.
- Families and carers were involved in care where appropriate. Weekly meetings were held to review patient's progress. Following the meeting carers were either given a copy of the progress sheet or a copy was posted to them.
- Carers had access to a support group. The provider invited carers to informal gatherings, for example, garden parties. There was a patient and carer's lead. The provider was planning to open a carer's hub in May 2018.
- Weekly community meetings took place, these allowed patients to raise concerns and provide feedback about the wards. The minutes of the meetings showed that actions had been taken following the meetings.
- The provider completed an annual patient experience survey. This was distributed via wards. Patients were encouraged to feedback via an opinion site on the internet.
- Care and treatment plans demonstrated the involvement of patients. For example, care plans were signed by patients where appropriate to show their agreement. Patients said staff took into account their personal, cultural and social needs into account especially when planning activities.
- The Men's service had a patient group, chaired by a patient. This group reviewed patient feedback and complaints to pick up any themes. One theme identified was that some patients had not had a care review for over a year. The group took action to address this, which included contacting commissioners. Patients were involved in monitoring and decisions about the service through a variety of groups and panels including a patient led group involved in auditing care plans and the reducing restrictive practice group. Patients also sit on the panels for recruitment and there is a patient panel at staff inductions.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- The average bed occupancy over the six months preceding this inspection was 87% on Ashby ward, 98% on Church ward and 94% on Fenwick ward.
- Patients were not moved between wards during an admission unless justified on clinical grounds.
- Patients going on leave would have a bed to return to.
- The men's rehabilitation wards did not report any delayed discharges in the 12 months prior to this inspection. The average length of stay was 43 days on Ashby ward, 297 days on Church ward and 191 on Fenwick ward.

The facilities promote recovery, comfort, dignity and confidentiality

- Wards had a variety of rooms for patients to use including quiet, therapy, fitness and activity rooms.
- Patients were able to make phone calls in private. Church and Fenwick wards were evaluating patients having their own personal mobile phones.

Long stay/rehabilitation mental health wards for working age adults

Good

- There was access to outside space and this was appropriate for patients.
- Patients said the food was very good and they were able to have a take away meal once a month. Each patient had their own space in which to store snacks and drinks. The kitchen fridge on each of the wards contained open items of food. However, the food was not labelled as to when it had been opened and when it should have been consumed by.
- Patients could make hot drinks and snacks were available from 6am to 11pm and then on request from 11pm to 6am.
- Patients were able to personalise their bedrooms. Patients had a lockable cupboard in their room to store their possessions, restricted items were store in a locked room and staff supported patients to access these items.
- Wards had a weekly therapeutic activity timetable, staff supported patients with social activities at weekends.

Meeting the needs of all people who use the service

- Wards had suitable access and facilities for patients requiring disabled support. Wards had accessible toilet facilities but did not have a disabled bathroom. However, all bedrooms had an en suite shower room, which was large enough to accommodate a shower chair.
- Staff could access information leaflets in a variety of languages for patients whose first language was not English. Staff had access to interpreters and translation services.
- Posters were displayed in communal areas to advise patients how to make a complaint, treatments available and how to access advocacy.
- The hospital catered for all dietary and religious requirements.
- St Andrews provided a chaplaincy service that provided patients with access to support from a variety of religions and faiths.

Listening to and learning from concerns and complaints

- The wards had received three complaints in the 12 months prior to this inspection. Each ward had received one complaint. Two of the complaint investigations were ongoing and the third was not upheld. None of the complaints had been referred to the ombudsman.
- Staff described how they would manage complaints appropriately.
- Staff supported patients on how to make a complaint. We saw information around the wards on how to make a complaint.
- Patients told us they were able to raise a complaint or issue in the community meetings, these issues were recorded and highlighted to staff in team handovers and with managers. Feedback was given to the complainant at the community meeting, where appropriate or to the patient on a one to one basis.
- Ward meeting minutes described feedback following the outcome of complaints.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

Vision and values

- Staff described the provider's vision and values and how they implemented these in their care and treatment of patients, for example putting people first and valuing each person as an individual.
- Staff outlined the senior management structure and gave examples of visits that have taken place on the wards by the senior management team.
- Staff knew the most senior managers in the organisation, and spoke positively about the support received from the operational and clinical leads.

Good governance

- The service had governance structures in place. Monthly ward management governance meetings were held involving staff and patient representatives where learning was shared and recorded in the meeting minutes.
- The service held a Monday morning meeting to review the past week, discuss issues and agree actions going forward.
- Managers monitored staff compliance with their mandatory training. Compliance rates were 93% for Ashby ward, 98% for Church ward and 100% for Fenwick ward.

Long stay/rehabilitation mental health wards for working age adults

Good

- Managers ensured that staff had received an annual appraisal.
- Ward managers were able to adjust staffing levels to meet the changing needs of patients requiring high levels of monitoring linked to risks. Managers ensured there were sufficient numbers of staff to meet clinical need.
- Managers ensured incidents were managed and reported effectively. Staff were supported following serious incidents. Patients said they received positive support following incidents on the wards.
- Key performance indicators were reviewed and monitored by managers for this service, these included sickness, absence monitoring and training compliance.
- Managers said had sufficient authority to complete their role, had access to a dedicated ward administrator.

Leadership, morale and staff engagement

- The sickness rate for Ashby ward was 6%, Church ward 0.6% and Fenwick ward 1%.
- Managers and staff were aware of, and demonstrated the Duty of candour placed on them to inform people who use the services of any incident affecting them.
- Staff had an awareness of the St Andrews whistle blowing policy and said they could raise concerns without fear of victimisation. Staff said they also could use the St Andrews safe call phone line to report any concerns. We reviewed six whistle blowing cases from May 2017 to February 2018. Of these, two were upheld, three were partially upheld and one was on going. All of the concerns raised in these cases came through the providers 'safe call' system. This is a confidential telephone and email system provided by an independent organisation for staff. Managers had investigated all whistle blowing cases within required timeframes.
- Staff reported positive morale within the ward teams and felt supported by their senior managers.
- We found that career progression was encouraged. Advanced clinical practice modules were available via a local university. There were leadership development opportunities, including accredited training for new and aspiring managers, full leadership programmes for nurse managers and operational leads and training for senior clinicians to become approved clinicians. Managers and staff said that there were opportunities both internally and externally for training and development.
- Staff described how they would talk with patients when something went wrong in an open and transparent way.

Commitment to quality improvement and innovation

- At the time of the inspection, the men's long stay/ rehabilitation wards were not taking part in any national quality improvement or accreditation programmes.
- Since the May 2017 inspection, the governance arrangements on the rehabilitation wards had improved and there were opportunities for staff to look at improvements on an ongoing basis via the ward management governance meetings.

Requires improvement

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Requires improvement

Safe and clean environment

On Foster ward -

- Foster ward was based over the first and second floors of the building. The building was old and the provider was in the process of moving wards out of this building into more modern facilities. Staff had not created personal emergency evacuation plans for patients. These would be used in the event of a fire. The provider had some slide slings but no evacuation chairs, for moving patients with limited mobility down stairs in the event of a fire. Staff did not have a clear understanding of fire processes and procedures nor where the slide slings were kept. A stairway to be used in the event of fire was not marked as such. The safety advisor had carried out a fire drill on Foster ward on 22 March 2018 but made no recommendations for improvements. At the time of inspection, managers immediately began to develop patient personal emergency evacuation plans and reviewed the ward fire procedures.
- On Foster ward staff were unaware of the ligature risk audit. The audit was incomplete, for example; the patient's activity room was not included. The ward layout meant that staff could not observe all areas of the ward. Staff used convex mirrors and close circuit television monitoring to observe communal parts of the ward.
- Access to the ward for people with reduced mobility was via a lift. Information previously gained by CQC team identified that the lift to the first floor was often out of use. On the second day of the inspection, the lift had been identified as being out of use on the first floor but not on the ground floor. This meant that patients and staff entering the lift on the ground floor were unaware of problems with the lift. The lift was very small, with a capacity of three adults or one adult and a wheelchair.
- The ward's décor and furnishings were poor. The ward and one bedroom had an underlying unpleasant smell. Curtains were hanging off the rail in the main lounge area. Paint was peeling in the dining area. There was a burst pipe in the kitchen that had burst previously. A bucket was placed underneath to catch the water. Estates had been informed. We found equipment displayed stickers that had passed its expiry date or safety testing date 2016. There were exposed electrical cables behind the door leading to staff offices.
- One toilet out of three toilets for fifteen patients was blocked at the time of the inspection. We were told this was a frequent occurrence. Paper hand towels were not available to patients to dry their hands, they had to use toilet roll instead. This was due to one patient placing paper towels in the toilet bowl.
- Handrails to help prevent patients with mobility problems from falling were not in all communal areas of the ward. We saw a patient balance himself using the windowsill to enable him to stand.
- The staff areas rooms, on the second floor, were in need of decoration with some broken seating. There was no designated staff rest room. The room used as a staff room was small, furnished poorly and served as an interview room on occasion.

- We saw a metal height-measuring stand stored on the communal ward area. We informed staff at the time who agreed to move it due to the potential risk of it being used as a weapon.
- The clinic room refrigerator door was broken and unlocked. We brought this to the attention of staff at the time and were informed this had already been reported. The refrigerator temperatures were logged daily.

On both wards -

- We observed that hotel service assistants' staff kept the ward environments visibly clean. Staff used food probes to ensure that food was heated to the correct temperature and this was recorded whenever hot food was served. The temperature of the ward refrigerators in the kitchens was regularly recorded.
- Staff were allocated responsibility as 'safety officer' for the shift. This involved monitoring fire tally cards, checking the identification of visitors and the observations board.
- Clinic rooms were fully equipped. There was rapid access to doctors, both day and night. Emergency equipment was kept at O'Connell ward and Thornton ward. Staff on these wards had responsibility for regularly checking the equipment.
- The provider had undertaken a full internal audit of infection control following the last inspection. This led to the introduction of an infection control assurance process, which includes unannounced reviews and spot checks.
- Staff used plastic bags to line rubbish bins on the ward. We found a roll of large orange plastic bags on a shelf in the corridor area. The provider had identified plastic bags as contraband and not to be brought onto the ward due to risk to patient's intent on self-harm.
- Staff carried personal alarms and call bells were in patient bedrooms to summon help if needed.
- Staff used convex mirrors and close circuit television to observe all communal areas of the wards that were not within lines of sight. On Cranford ward the nursing station was positioned to ensure clear lines of sight to the communal areas.
- Patients had access to nurse call systems to summon help when required.

Safe staffing

- The provider used an electronic tool in order to calculate levels of staffing. The system recorded daily staffing numbers and rostering on both wards.
- On Foster ward, staff were frequently engaged in supporting patients at a rate of two staff to one patient. At the time of the inspection, patient's ages ranged from 38 to 95 years presenting staff with a wide variety of care and treatment needs including high levels of personal care, dementia considerations and management of potential violence or aggression. Escorted leave was sometimes cancelled due to the challenges of managing the patient's needs. Agency nurses were not always familiar with the ward or patients.
- On Cranford ward, at the time of the inspection, two patients needed help with self-care. Due to their illness, it took three people to undertake this task, leaving the ward short staffed on occasion.
- Both wards operated on an 'A' and 'B' team shift system, alternating throughout the year. Shifts ran from 07.30 a.m. to 07.45p.m and 7.30p.m to 07.45 a.m. for five out of seven days. The following week staff worked for two out of seven days. The establishment levels for Cranford ward was 11.7 qualified nurses and 16.6 healthcare assistants. The day shift on Cranford ward comprised a clinical nurse lead, three qualified nurses and four healthcare assistants. At night, two qualified nurses and three healthcare assistants covered the shift. On Foster ward, the establishment levels were 9.6 qualified nurses and 12 healthcare assistants. The day shift on Foster ward comprised a clinical nurse lead, three qualified nurses and six healthcare assistants during the day and one qualified nurse with six healthcare assistants at night. Staff on both wards had a break of one and a half hours within their shifts.
- Data showed that between October and December 2017, 245 shifts had been covered by bank staff and 120 by agency staff. Eighty four shifts (19%) had remained unfilled in this period. On Foster ward for the same period, 88 shifts had been filled by bank staff and 41 by agency staff. Fifty five (30%) shifts had remained unfilled.
- Between January and December 2017, Foster ward carried a vacancy rate of 3.5% and a sickness rate of 7%. Cranford ward had a sickness rate of 4%. Although the data showed there were no vacancies during this period, data also showed that four staff had left
- Staff were up to date with mandatory training. Overall staff were 95% compliant.

- There were qualified nurses in the communal areas at all times. There was 24 hour access to a psychiatrist.

Assessing and managing risk to patients and staff

- We looked at 12 care records and found that risk assessments were undertaken prior to a patient being accepted in the service and regularly thereafter. A risk tool was completed for each patient.
- On Foster ward we saw that positive behavioural support plans were in place for each patient that included crisis plans.
- All records were stored electronically. In addition, hard copies of basic information about patients was available for bank or agency staff to access easily. All staff were able to make patient entries and to access information they needed.
- Staff used a recognised risk assessment tool, the 'historical clinical risk 20'; a structured clinical judgement risk assessment tool to assess the risk of violence.
- Staff were identified as 'responders' on each shift. This meant that when a ward needed help to manage deterioration in the patient's mental health, extra staff were made available.
- Staff were fully trained in safeguarding as part of their mandatory training programme. Staff knew what to look out for and how to report any concerns relating to safeguarding.
- On Foster ward, one toilet out of three was blocked at the time of the inspection. We were told this was a frequent occurrence. A blanket restriction was in place that meant that toilet roll had to be used instead of paper towels for patients to dry their hands as one patient blocked the toilets by putting paper towels in the bowl.
- Staff were clear on the use of observations and the associated policy. We saw that the observation records were complete on the days of the inspection although previous records showed some gaps.
- Information collected prior to the inspection showed that prone (face down) restraint had been recorded on three occasions between July and December 2017 on Cranford ward. There had been 111 episodes of restraint recorded in the same time. Of the 111 episodes of restraint, eight patients had been involved. Information provided indicated that one patient had been restrained using low-level holds regularly due to preventing him from serious self-harm. Holds had to be used when moving patients to the seclusion room.
- There had been 31 episodes of seclusion from July to December 2017. On Foster ward, data showed that two episodes of seclusion had occurred during the same period.
- We reviewed two seclusion records from January 2018 to March 2018. Doctors had not completed a medical review within an hour of seclusion commencing in line with the Mental Health Act Code of Practice in one out of two records. Continuing medical reviews had not been completed in one out of two records. Staff had not completed seclusion care plans in one out of two records.
- On Cranford ward, in one patient's record, we noted the doctor had undertaken a medical review over the telephone. There were no entries on the charity's electronic recording system of the medical reviews. In another patient's record, there were no entries on the charity's electronic recording system of the medical reviews.
- The seclusion room was last used 19 March 2018. The manager reported seclusion was rarely used.
- The provider had recently implemented an audit of seclusion practices in order to improve compliance with the Mental Health Act code of practice.
- On Foster ward, between July and December 2017, there had been 11 episodes of restraint on five patients and no prone restraints.
- Staff used 'management of actual or potential aggression' techniques to manage patients whose moods were deteriorating. Staff recorded all 'holds' as restraint, including the laying on of hands in a guiding manner.
- We saw that two staff dispensed medicines to patients individually at the clinic door. We checked the controlled drugs register on Foster ward and found that a signature list of staff able to administer controlled drugs was unavailable. We also found that page numbering was incomplete for one patient's controlled drugs record. Prescriptions were managed electronically.
- Guidance on the use of rapid tranquillisation medication was displayed in the clinic rooms. Staff said they had not used this form of medication for a long time. Data provided reflected that no rapid

tranquillisation had taken place between January 2017 to December 2017. Managers confirmed rapid tranquillisation medication was used between January and March 2018 on Cranford ward once and Foster ward three times. There was a poster displayed with the protocols to follow when administering rapid tranquillisation medication.

- We noted that two patients were administered medications covertly. We checked that this was correctly care planned and agreed by the multi-disciplinary team and found robust records to support this.

Track record on safety

- We reviewed the provider's incident database. As of 28 March 2018 there were 360 incidents awaiting review, of which 263 were overdue.
- The provider has been working with NHS England to review their reporting of serious incidents. The provider told us that they over report serious incidents. The provider has recently implemented an internal serious incident review group. This group meets once a month and reviews all serious incidents reported in the last month. The group will agree if the incident is a serious incident or if it needs to be downgraded. The learning lessons group has merged with the serious incident review group. The review group also set terms of reference for any investigations.
- Data supplied by the provider showed three serious incidents having occurred on Cranford ward between June and August 2017. These included one slip or trip, one accident and one commissioning incident. On Foster ward there had been one serious incident recorded of alleged assault or abuse by staff on a patient.

Reporting incidents and learning from when things go wrong

- Staff told us about the procedures for reporting incidents and how to complete incident forms on the intranet.
- The provider had an 'open and honest care' policy. The policy included links to the Health and Social Care Act regulations. A Duty of candour observation group met monthly to review all notifiable safety incidents and checked that staff had taken action in line with Duty of candour requirements. Staff, while not always understanding the term 'Duty of candour' described how they would be open and honest with patients should something go wrong and that they would offer an apology to patients as part of this process.
- There was little evidence to show that learning from incidents external to the ward had taken place. Learning from incidents having occurred on the ward was shared via staff handover. We were told that psychology input was available to support staff following incidents.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff completed a comprehensive mental health and physical health assessment of each patient prior to them being accepted for care and treatment at St Andrew's Hospital. Staff assessed the patient's ongoing physical health and mental health needs regularly and noted them in the care plan following any incidents, multi-disciplinary team meetings and patient care and treatment reviews.
- Care records showed that detailed positive behaviour support plans were in place for patients on Foster ward. These included triggers to risk, crisis plans, patient strengths, patient preferences and management plans.
- Information about patient care and treatment was stored electronically and in hard copy for use by staff unfamiliar with the patient. However, we found minutes of a care programme approach review in the folder for blank section 17 leave forms on Cranford ward.
- We saw little evidence that care and treatment focused on rehabilitation on Foster ward.

Best practice in treatment and care

- We saw that medications were prescribed following National institute for Health and Care Excellence guidance. Where antipsychotic medications were high according to British National Formulary guidelines, a second opinion independent doctor was consulted. We saw that patient photographs were held alongside prescription charts.

Requires improvement

Wards for older people with mental health problems

- Staff supported patients to access psychology input in line with National Institute for Health Care Excellence guidance. This included cognitive stimulation therapy and anxiety management.
- On Cranford ward, three mealtime sittings were held to accommodate the needs of patients. The first sitting was of an ordered structure, the second for more disturbed patients and the third for one patient who needed support with eating.
- Staff used rating scales such as the Health of the Nation Outcome Scales to monitor patient outcomes and a red, amber, green rating scale for key areas of care and treatment.
- The provider had implemented a new system for audits. Work was in progress to improve processes to give greater assurance. Audits were linked to compliance and legislation.

Skilled staff to deliver care

- While there was access to nurses, doctors, technical instructors, psychologists, speech and language therapists and physical health nurses, dieticians and support workers, there was limited access to occupational therapy. While employed on a full time basis, there was only one occupational therapist to cover both Foster and Cranford wards. This meant they could only offer limited input due to the challenges of managing the diverse patient group on a day-to-day basis.
- At the time of the inspection, there was a vacancy for an occupational therapist on Cranford ward and for a social worker on Foster ward.
- Staff were experienced and qualified to care for this patient group.
- Staff spent time completing a full induction before working on the ward. This included mandatory training in the Mental Capacity Act, the Mental Health Act, Management and Prevention of Aggression and safeguarding.
- The provider had introduced a new management supervision policy in November 2017.The service reported an overall rate of 78% for management supervision from 1 November 2017 to 30 March 2018. In March, the overall rate was 98%. Staff on Cranford ward received regular clinical and managerial supervision. Staff on Foster ward tod us they had not received regular clinical and management supervision over the 12 months prior to inspection. Foster ward reported a rate of 60% for management supervision and 75% for clinical supervision. However, staff had attended reflective practice sessions.

Multi-disciplinary and inter-agency team work

- We saw records that showed that effective handovers had taken place for each shift.
- We attended a safeguarding meeting on Foster ward. Staff discussed a worsening of a patient's physical condition was due to poor information sharing between the teams.
- There were strong relationships with the external care co-ordinators, commissioning groups and GPs.

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

- Training on the Mental Health Act and Mental Capacity Acts was 100% compliance on both wards. There was a Mental Health Act office on site to help staff deal with any queries. Policies and procedures were available on the provider intranet.
- We looked at six section 17 leave records on Foster ward. Patients were unable to access fresh air if they wanted unless they were escorted or a section 17 leave for unescorted leave had been granted. This was especially important as three patients on Foster ward had significant mobility difficulties and were reliant on staff to enable them to get down stairs to the garden area. The conditions of leave did not always state if section 17 leave was being granted as part of a rehabilitation plan; or as a routine requirement to enable the patient group to access fresh air.

Good practice in applying the Mental Capacity Act

- 'Capacity' was documented on some positive behavioural support plans. However, staff we spoke with during inspection struggled to define what 'capacity' meant.
- Best interest meetings, when held, were documented.
- Consideration of capacity assessment was completed in care records by clinical staff
- The provider had a policy on the Mental Capacity Act to which staff could refer if needed. A Mental Health Act team was available for support.

Requires improvement

Wards for older people with mental health problems

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

- We observed attitudes and behaviours that helped patients manage their emotions. Staff talked kindly to patients and listened to them carefully in order to meet their needs.
- Although physical care was delivered discretely, in the patients bedroom behind closed doors, one patient was being nursed on one to one observations in his bedroom with a member of staff sat in the doorway. This patient needed a lot of personal care and was liable to being observed and heard easily from the main corridor. This affected the patient's dignity.
- Staff supported patients to eat in an unhurried way, and often sat down with the patients to eat with them, providing opportunities to monitor and engage therapeutically with patients.
- We saw staff explaining to patients about aspects of their care and treatment.
- Staff explained to us the individual preferences and needs of their patients, including faith, social and personal aspects.
- Patients spoke highly of staff care and attention.

The involvement of people in the care they receive

- We saw that the majority of care plans had included the views and wishes of patients in their creation. Records did not always indicate that patients had received copies of their care plans. Patients were invited to attend care programme approach reviews, as were their relatives if appropriate.
- Carers had access to a support group. The provider invited carers to informal gatherings, for example, garden parties. There was a patient and carer's lead. The provider was planning to open a carer's hub in May 2018.
- Patients had access to one to one's and community meetings to offer feedback about the service. The provider completed an annual patient experience survey. This was distributed via wards. Patients were encouraged to feedback via an opinion site on the internet.
- Advocacy services were available on both wards. Advocates attended weekly to meet up with patients if they needed help.
- The Men's service had a patient group, chaired by a patient. This group reviewed patient feedback and complaints to pick up any themes. One theme identified was that some patients had not had a care review for over a year. The group took action to address this, which included contacting commissioners. A patient led group was involved in auditing care plans. A patient sits on the reducing restrictive practice group. Patients sit on the panels for recruitment and there is a patient panel at staff inductions.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

- At Cranford ward, bed occupancy was 100%. This was above 85%, which is considered to be a good practice benchmark by the Royal College of Psychiatrists and NHS to ensure quality of care. This impacted on patients access to leave and activities.
- There had been no delayed discharges. There was always a bed available on site on the psychiatric intensive care unit.
- Average length of stay on Cranford ward was 245 days and on Foster ward 202 days.
- Patients were not moved between wards unless clinically justified.

The facilities promote recovery, comfort, dignity and confidentiality

On Foster ward –

- There were no en-suite bedrooms. Patients were able to personalise their bedrooms.
- Staff and patients did not have enough access to space. Rooms were being used for dual purposes, for example the staff room was used as an interview room and the

patients activity room was used as a ward round room. There were no designated quiet rooms. However a quiet room had been identified but no plans were in place to refurbish the room.
- Some bedrooms opened onto the main lounge area where all patients sat during the day. This meant that patients were subject to the noise from other patients in the lounge area.
- Some bedrooms were off a corridor leading to the dining room and toilets/shower rooms where all patients passed. When patients were nursed on one to one observations who needed personal care, we observed that staff did not always consider the proximity of other patients when moving in and out of the patient's bedroom.
- Hand rails were not in place to enable patients at risk of falls to move around the ward more safely. We observed one patient use a windowsill to pull him upright as there was no handrail to help him. One elderly patient had fallen in the evening of the first day of inspection.
- Taps in bathrooms had to be pushed down to make the water run, meaning only one hand could be washed at a time. All the wash hand basins were very small.
- The ward telephone was near the main entrance in a communal area. Patients could not make a phone call in a private area.
- Patients were supported to lead healthier lives. Staff held patient's cigarettes and alcohol and other substances were not allowed on the ward. Staff escorted patients to the outside of the hospital grounds for cigarette breaks.
- Patients could not access outside space for fresh air without being escorted or without unescorted leave arrangements being in place. This particularly affected the older more frail patients who were reliant on staff to help them with mobility issues they faced in order to get downstairs and who were unsuitable for unescorted leave.

On Cranford ward;

- Bedrooms were en suite and the environment was light and airy. Patients were able to personalise their bedrooms.
- There were designated rooms for use for activities and meetings.
- A visitor's room was within the main part of the building.
- Some patients held their own bedroom keys.
- One patient told us they enjoyed going to the woodwork club to make items.
- A patient phone was available to make private calls.
- The communal garden area had seating but was otherwise stark. The outdoor area did not provide a positive therapeutic experience.

On both wards –

- There was a diverse menu on offer. Access to food and drinks was restricted to set times. Patients could request snacks and drinks outside of these times. Staff response time to requests was dependent on how busy the ward was.
- There was limited access to activities due to staff prioritising immediate patient support.

Meeting the needs of all people who use the service

On both wards-

- Food was of good quality with a good choice. We observed mealtimes on both wards. We noted that patients were helped as needed and their wishes respected. We saw a health care assistant feeding a patient and noted that what he had eaten and drunk was recorded.
- Patient's religious and cultural food requirements were met.
- There were disabled facilities including specially adapted baths and toilets. Access to Foster ward was via a small lift or stairs. The lift was labelled as out of use on the day of the inspection. We were told that it was often out of use.
- We saw information about how to complain and patient rights displayed.
- We saw that interpreters were available to help patients needs be understood.
- Access to spiritual support was available on site.
- On Foster ward, we observed a patient reading a newspaper that had been provided in the patient's own language. We saw signs around the ward also in the patient's own language. On Cranford one patient requested a Welsh newspaper so they could keep up with local news.

On Foster ward:

Requires improvement

Wards for older people with mental health problems

- Staff did not have any patient information about the ward to be given to help orientate the patient. We requested this information following the inspection, but this was not provided.

Listening to and learning from concerns and complaints

- Staff knew how to manage complaints. Staff told us how they would refer patients to advocacy services if they felt they needed support.
- Staff were vague about the process of feedback from complaints investigations. Most staff felt that complaints would be resolved at local level. Cranford ward received three complaints between June and September 2017. Foster ward did not receive any complaints between January 2017 and December 2017.

Are wards for older people with mental health problems well-led?

Requires improvement

Vision and values

- Staff varied in their understanding of the provider's vision and values.
- Staff described feeling distant from the senior leadership team. Staff felt unsure of the future direction of travel for Foster ward.

Good governance

- During the past 12 months since the last inspection on Foster ward, supervision had ceased and staff felt unsupported.
- On Foster ward key performance indicators had been allowed to lapse. Staff did not know how well their team was performing.
- Managers were able to access information about their teams from a central area. There were regular governance meetings. However, this was not being used to good effect.
- Managers had not managed risks around premises and in particular fire safety on Foster ward.

Leadership, morale and staff engagement

- The manager of Foster ward had only been in post for six weeks and was due to leave in June, when a new manager came into post. There had been eight managerial changes in the ward over the past 24 months. Sickness and absence rates were high, morale was low. However, teams supported each other and described a sense of togetherness.
- On both wards, managers were working hard to support staff including working with staff in direct patient care.
- We reviewed six whistle blowing cases from May 2017 to February 2018. Of these, two were upheld, three were partially upheld and one was on going. All of the concerns raised in these cases came through the providers 'safe call' system. This is a confidential telephone and email system provided by an independent organisation for staff. Managers had investigated all whistle blowing cases within required timeframes.
- Managers had attended or were booked onto the provider's leadership course. We found that career progression was encouraged. Advanced clinical practice modules were available via a local university. There were leadership development opportunities, including accredited training for new and aspiring managers, full leadership programmes for nurse managers and operational leads and training for senior clinicians to become approved clinicians.
- On Foster ward, the patient mix ranged from 38 years (one patient) to 95 years and this proved challenging to meet patients care and treatment needs. Some staff described it was difficult to provide activities. The Foster ward manager told us from 1 April 2018 there would be new patient care pathways and was confident there would be improvements.

Commitment to quality improvement and innovation

- There was little evidence of learning, continuous improvement or innovation.
- Staff were aware of award schemes being run by the provider.

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- Staff were able to observe all areas of the ward on Mackaness. The layout of Harlestone ward allowed staff to observe most parts of it. Staff mitigated risks in all wards via constant staff presence in high risk areas. Rooms were locked when not in use.
- Managers had identified ligature points throughout the wards. Staff identified these via annual ligature audits. A ligature point is a place to which patients intent on self-harm could tie something to harm themselves. Staff managed identified risks with nursing observations and we observed staff were in patient areas at all times.
- The provider was compliant with the Department of Health's guidance on the provision of single sex accommodation. All wards were single gender.
- Clinic rooms were well equipped and stored emergency drugs. Staff checked equipment regularly. Staff had access to resuscitation equipment and emergency medication.
- Seclusion rooms on Hawkins, lower Harlestone and Mackaness wards allowed clear observations. However staff were unable to view the patient clearly on Naseby ward, as there was a blind spot. All seclusion rooms had two-way communication, toilet facilities and a clock.
- Ward areas on Harlestone and Watkins wards were not clean. The kitchen surface, fridges and freezer on upper Harlestone, and the fridge, toilet and shower at Watkins house were dirty. We also found boxes of bandages and dressings on the floor in the clinic on Watkins house.
- Wards had good furnishings and were generally well-maintained. However, on upper Harlestone, there was paint peeling off a patient's bedroom wall and the kitchen surface was worn.
- The provider had undertaken a full internal audit of infection control following the last inspection. This led to the introduction of an infection control assurance process, which includes unannounced reviews and spot checks. Staff adhered to infection control principles including handwashing. Hand gel dispensers were in place in communal areas and we observed staff using these during our inspection. However the hand gel dispenser on the main entry to Mackaness and Hawkins wards was empty.
- The provider had not ensured all medical equipment was regularly tested to ensure it was in working order. On upper Harlestone ward, we found staff had not regularly tested the oximeter and blood pressure machine. We identified this during the clinic check and staff spoken with could not remember the equipment being checked.
- We observed housekeepers cleaning the ward during inspection, and ward areas on five of the seven wards were generally clean.
- The service had up to date, thorough environmental risk assessments including ligature risks and health and safety assessments.
- Staff had access to appropriate alarms to call for assistance in case of an incident.

- Patients had access to nurse alarm systems to summon help when needed.

Safe staffing

- Managers used a recognised model to calculate nurse staffing levels. This model was being rolled out to other professional groups. There were eight (13%) qualified and seven (7%) support worker posts vacant across the service at the time of inspection.
- The provider reported sickness rates of 8% across the service from 1 January 2017 to 31 December 2017. Mackaness reported 4%, Harlestone 6%, Glendale 7%, Garden Cottage 2%, Hawkins 7%, Naseby 4% and Watkins House 3%.
- Wards were not always covered with the required number of staff for care and treatment. Staff advised the number of nurses did not match the recommended staffing levels number on all shifts. Managers submitted data, which confirmed that 13% of shifts had not been filled by bank or agency over a three month period. The service used bank and agency staff across all wards to maintain safe staffing numbers. Between 1 October 2017 and 31 December 2017, bank or agency staff filled 1,770 shifts to cover sickness, absence or vacancies. The highest use of bank and agency staff was on Hawkins ward, which accounted for 45% of additional staff usage.
- Managers ensured agency and bank nurses were familiar with the wards where possible.
- Managers adjusted staffing levels daily to take account of case mix, patient need, and level of observation. The service often had difficulty in finding staff to cover shifts at short notice. Staff and 70% of patients on Hawkins, Naseby and Harlestone wards confirmed that the wards were often short of staff.
- Staff and patients on Harlestone, Hawkins and Naseby advised that escorted leave and ward activities were frequently cancelled due to staff shortages. The other wards did not report this an issue.
- Staff were present in communal areas of the wards and observing patients at all times.
- The service had sufficient medical cover for safe care and treatment. Medical cover was provided by a consultant psychiatrist and an associate specialist registrar grade doctor.
- We reviewed the medical first on call and twilight on call logs for the whole Northampton site (four locations) from 2 September 2017 to 19 March 2018. A total of 5,388 hours of medical on call cover was provided over this period. The on call doctors completed 3,186 tasks within these hours, equating to an average of 0.6 tasks per hour. Of these tasks, 1,318 (23%) related to seclusion. Based on each seclusion task taking an average of 20-30 minutes, this equates to 549 hours (10%) of the total on call hours provided.
- Of the total tasks 694 (22%) related to the Men's services. Of these 327 (47%) related to seclusion tasks, equating to 136 hours of on call time.
- Doctors advised that they were not always able to complete seclusion reviews within the timescales required by the Mental Health Act code of practice. They provided additional data relating to weekend on call cover for 30 weekend days from August 2017 to March 2018. A total of 368 tasks were provided in 88 hours. This equated to an average of four tasks per hour. Of these 212 (58%) were seclusion tasks which takes the whole 88 hours. Men's services accounted for 108 tasks, of which 73 were seclusion tasks, totalling 30 hours (34%) of on call time.
- The provider had completed a review of the hospital at night. A working group was looking at actions required to address the issues the review had raised. Plans were in place to increase the provision of physical healthcare at night to relieve some of the pressure on the on call doctors.
- Staff received and were up to date with mandatory training. The provider's compliance target for mandatory training was 95%. Most wards had achieved this.

Assessing and managing risk to patients and staff

- We looked at 16 care records which all contained risk assessments. Staff undertook a risk assessment of every patient on admission. Staff had not updated three risk assessments following incidents.
- Staff used recognised risk assessment tools throughout the service, which were accessible by all staff for review. These included the historical clinical risk management-20 for secure environments (HCR-20) tool, which is a comprehensive set of professional guidelines for the assessment and management of violence risk.
- Staff used blanket restrictions only when justified and where risk assessed. Staff observed patients when accessing cutlery and outside areas due to the level of risk.

Requires improvement

Wards for people with learning disabilities or autism

- The hospital had policies and procedures for use of observations (including to minimise risk from ligature points) and searching patients.
- Staff did not always complete enhanced patient observations in line with patient care plans or the provider's policy. On one occasion on Hawkins, a staff member left their post, leaving only one staff member with a patient assessed as requiring 2:1 observations at all times.
- Managers reported 114 recorded episodes of restraint between 1 July 2017 and 31 December 2017. These were highest in Hawkins and Naseby wards, with 43 and 45 episodes of restraint respectively. These episodes of restraint involved 18 patients across both wards. There were 23 episodes of prone restraints, which accounted for 21% of all recorded restraints. These were highest in Hawkins and Naseby with 11 and 12 episodes of prone restraint respectively. This was a reduction from the previous inspection when there were 42 episodes of prone restraint recorded in a six month period.
- Managers submitted data on restraints for the last six months. This did not show a marked reduction in the number of restraints over this period.
- Staff and managers told us they used the least restrictive option possible in response to episodes of violence and aggression. Restraint was only used after de-escalation had failed and using correct techniques.
- Staff were able to access a rapid tranquillisation policy for guidance on the management of patients with extreme episodes of agitation. These medicines were to be given only when de-escalation techniques had failed to work. Rapid tranquillisation was not used very often and the service reported they had used it once, on Hawkins ward, between 1 July 2017 and 31 December 2017.
- We inspected the seclusion facilities on Hawkins, lower Harlestone, Mackaness and Naseby wards, and noted a number of issues. These included minor damage to the observation window frame on the external seclusion room door on Hawkins ward, an unpleasant smell from drains on Mackaness ward and a blind spot between the seclusion and en-suite area on Naseby ward.
- Managers reported 97 episodes of seclusion between 1 July 2017 and 31 December 2017. These were highest in Hawkins ward, who recorded 46 episodes of seclusion. This was a reduction from the previous inspection when there were 99 episodes of seclusion recorded in a six month period.
- There had been one reported episode of long term segregation in the six months prior to inspection. However, we raised concern about the care and treatment of one patient on lower Harlestone ward, which could have been viewed as long term segregation. Managers responded quickly and responsively in reviewing the patient's plan of care.
- We reviewed 20 seclusion records from January 2018 to March 2018. Doctors had not completed a medical review within an hour of seclusion commencing in line with the Mental Health Act code of practice in nine out of 20 records (45%). Nurses had not completed reviews required in line with the code in eight out of 20 records (40%). Continuing medical reviews had not been completed in six out of 20 records (30%). Staff had not completed seclusion care plans in 16 out of 20 records (80%).
- We found that seclusion documentation did not meet the Mental Health Act code of practice. Seclusion records for one patient on Naseby ward showed that an episode of seclusion had commenced at 1400 hours. However, the doctor did not attend until 1800 hours. In another patient's record, we were unable to find any evidence of nursing reviews taking place during the patient's seven-hour period of seclusion. In a third patient's record, with the exception of a medical review, there were no entries in the progress notes about the patient's period of seclusion. The patient did not have a seclusion pack, or seclusion care plan for this episode of seclusion.
- On Hawkins ward, we examined the record of a patient who had self-harmed during seclusion and required attention by the duty doctor. There was no evidence of this happening in the progress notes. In another patient record, we expected to see 34 nursing reviews taking place during the patient's period of seclusion. However, we found only 19 of these reviews had taken place.
- We examined the records of a patient on Mackaness ward, who had been in seclusion for 25 hours, and could only find evidence of one review. We could find no evidence of nursing reviews taking place during another patient's four-hour period of seclusion.
- The provider had recently implemented an audit of seclusion practices in order to improve compliance with the Mental Health Act code of practice.
- Not all staff were in receipt of safeguarding training in accordance with the provider's policy. Managers have recently reviewed the provider's training for

safeguarding adults. Managers submitted data for the end of December 2017, which evidenced that 98% of staff had been trained in level one and two safeguarding and 52% of qualified staff had completed level three safeguarding training. Level three training was below the hospital target of 95%. However all staff knew how to make a safeguarding alert and did this when appropriate. Staff told us the ward social workers were the safeguarding leads and they could seek advice if needed.

- Wards had electronic prescribing, and staff managed medicines well. We inspected all seven clinic rooms and saw that there were effective medicine management practices. There was safe and appropriate storage, dispensing, and medicines reconciliation.
- Wards had safe procedures for children that visited. Visitor's rooms were available off the wards.

Track record on safety

- We reviewed the provider's incident database. As of 28 March 2018 there were 360 incidents awaiting review, of which 263 were overdue.
- The provider has been working with NHS England to review their reporting of serious incidents. The provider told us that they over report serious incidents. The provider has recently implemented an internal serious incident review group. This group meets once a month and reviews all serious incidents reported in the last month. The group agrees if the incident is a serious incident or if it needs to be downgraded. The learning lessons group has merged with the serious incident review group. The review group also set terms of reference for any investigations.
- The number of serious incidents reported in last 12 months was 14. The highest reporter in the period was Harlestone ward, having reported 13 serious incidents out of 14 for the pathway. The highest number of incidents reported related to allegations made by patients against staff. This included allegations of both verbal and physical abuse. The provider reported all allegations of abuse to the local authority safeguarding team. Managers had carried out investigations into the allegations and taken appropriate action.
- Managers had reviewed restrictive intervention training for staff in response to the high number of allegations against staff and new training techniques were now in place.

Reporting incidents and learning from when things go wrong

- Staff knew what situations required reporting as an incident and could describe the process for doing so. The service used electronic recording systems to record incidents and staff knew how to use the system.
- We found that not all incidents had been reported. Staff advised that they do not record incidents where staffing levels are below the recommended levels. The cancellation of patients' leave and activities due to poor staffing levels had not been recorded as an incident or in the patients' records.
- The provider had an 'open and honest care' policy. The policy included links to the Health and Social Care Act regulations. A Duty of candour observation group met monthly to review all notifiable safety incidents and checked that staff had taken action in line with Duty of candour requirements. Staff were open and transparent and explained to patients if and when things went wrong.
- Staff confirmed that they received feedback from investigation of incidents both internal and external to the service. This happened via handovers, team meetings and bulletins, which managers sent to all staff.
- Managers and staff were able to evidence changes having been made as a result of feedback. An example of this was the change in restrictive interventions, in response to patient complaints.
- Staff confirmed that they received debriefing and support after serious incidents.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We examined 16 electronic patient records. Only 31% had positive behavioural support plans. Those that had been completed were; colourful, comprehensive and of good quality. The records contained a number of strategies to a variety of known triggers and early

warning signs in relation to patients' behaviour and presentation. The provider advised, after the inspection, that positive behavioural plans were available in hard copy for all patients.

- Staff commenced patient assessments prior to a patient admission or transfer to the wards. Staff completed a full multidisciplinary assessment and treatment plan within 72 hours of a patient being admitted to the ward. Staff used the assessment template in the electronic record. Use of the autism diagnostic observation schedule was part of the assessment process.
- The provider had a physical health nurse who followed up on patients' physical health checks and provided the team with advice and support on physical healthcare issues. However, care records showed that whilst physical examination had been undertaken there was a lack of ongoing monitoring of physical health problems. We found a number of gaps in the recording of patients' temperature, pulse, blood pressure, weight and height in 56% of the16 records reviewed.
- We found that care records contained up to date, personalised, holistic, recovery-oriented care plans. Patients told us they were involved in both the development and review of their care plans.
- Staff had not always updated care plans following incidents.
- Staff used the trust's electronic patient record system for recording information.

Best practice in treatment and care

- Staff followed best practice in prescribing medication in accordance with National Institute for Health and Care Excellence guidelines. This was demonstrated in the rapid tranquillisation policy which indicated that medication should only be given when de-escalation techniques had failed. Managers had ensured that staff were following best practice in terms of positive behavioural support care planning for all patients. Staff attended a three day training course in positive behavioural support.
- Patients had access to psychological treatments as recommended by the National Institute for Health and Care Excellence. The team included psychologists and psychology assistants who delivered a variety of psychological treatments across the service.
- Managers had not always ensured that patients had access to physical healthcare; including access to specialists when needed. We saw an example where staff had not referred a patient who was hard of hearing, for an audiology appointment. We also found an example of a patient with asthma whose peak flow reading had not been recorded in line with the plan of care.
- Staff used a range of recognised rating scales to assess and record clinical outcomes for patients. Examples included the spectrum star, autism diagnostic interview - revised, autism diagnostic and the Health of the Nation Outcome Scale – secure.
- The provider had implemented a new system for audits. Work was in progress to improve processes to give greater assurance. Audits were linked to compliance and legislation. Staff participated in clinical audits. These included infection control, hand hygiene, and medication management.

Skilled staff to deliver care

- Wards had access to a wide range of disciplines to support patient care. The multidisciplinary teams included consultant psychiatrists and associate specialists. There was also occupational therapy, technical instructor, clinical psychologist, assistant psychologist, social worker, and qualified and unqualified nursing staff. All members of the multidisciplinary team attended ward reviews.
- Patients had access to specialists when needed. Wards had input from speech and language therapy, dieticians, and physiotherapists from a central team as required. The hospital pharmacist visited the ward weekly.
- Staff were trained to work with patients with a learning disability. Examples of specialist training included autism and sensory awareness.
- Staff received an induction prior to working on the wards. This included positive behavioural support, safeguarding, introduction to autism, reducing restrictive practices and the management of actual and potential aggression. Training was a mixture of online learning and face to face sessions. Staff also had a ward induction.
- Staff received monthly managerial and clinical supervision and yearly appraisal. Data for the men's learning disability wards showed an average annual appraisal rate of 87%, although the rate for Hawkins ward was 62%, which failed to meet the provider target of 85%. The average clinical supervision rate was 83% with the rate for Harlestone at 68% and Hawkins 72%, which failed to meet the provider target of 85%.

Requires improvement

Wards for people with learning disabilities or autism

- The service reported an overall rate of 66% for management supervision from 1 November 2017 to 30 March 2018. In March, the overall rate was 100%.
- Managers addressed staff performance through supervision, training and through their disciplinary process. We saw evidence through sickness monitoring, that when the provider became aware of performance issues they took appropriate action.

Multi-disciplinary and inter-agency team work

- Managers held monthly team meetings for staff to share information. However, on Harlestone and Mackaness wards team meetings did not occur regularly.
- Staff participated in weekly multi-disciplinary meetings for patients, although we found that a number of healthcare assistants had no access to these meetings.
- Managers communicated the outcome of multi-disciplinary reviews via an e-mail update. This was sent to every staff member and contained details of the discussion and required actions.
- Staff completed patient handovers at the beginning of each shift, where each patient's daily activities and details were handed over to the oncoming shift.
- Staff described effective joint working with other teams in the organisation. There were also effective working relationships with teams outside of the organisation, including local authorities, commissioners, and social services.
- The provider had effective systems in relation to reporting safeguarding concerns to the police, local authority, and the Care Quality Commission. The provider had developed good relationships with the local safeguarding team and commissioning teams.

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

- Mental Health Act detention paperwork was completed correctly, was up to date and stored appropriately.
- Staff knew who their Mental Health Act administrators were. Mental Health Act administrators supported staff to ensure the Act was adhered to, for example, renewals, consent to treatment and appeals against detention.
- Staff maintained clear records of leave granted to patients, although we found that not all occasions where leave was cancelled had been recorded as an incident.
- Patients and staff were aware of the parameters of leave granted, including risk and contingency and crisis measures. Staff confirmed that a risk assessment was undertaken prior to episodes of patient leave. We found evidence of this in patient records.
- Managers submitted data which show that 96% of staff have been trained in the Mental Health Act. Staff had a good understanding of the Mental Health Act, the code of practice and the guiding principles.
- Staff adhered to consent to treatment and capacity requirements, and copies of consent to treatment forms were held electronically, and on each ward in paper form. This ensured staff had access to the correct documentation to ensure medication was administered under the appropriate legal authority.
- Patients had their rights under the Mental Health Act explained to them on admission. These were undertaken routinely every three months, and recorded on a section 132 tracker.
- Administrative support and legal advice on implementation of the Mental Health Act and its code of practice was available from a central team
- The Mental Health Act team undertook regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from these audits.
- Patients and staff advised that they had access to the independent mental health advocate services. Staff were clear on how to access and support engagement with the independent mental health advocates as required.

Good practice in applying the Mental Capacity Act

- Ninety six percent of staff had training in the Mental Capacity Act, although we found staff understanding of the five statutory principles across the wards varied.
- Staff had not made any deprivation of liberty safeguards applications in the last 6 months.
- The hospital had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards, which staff were aware of and could refer to.
- Patients who might have impaired capacity, had their capacity to consent assessed and recorded appropriately.

Requires improvement

Wards for people with learning disabilities or autism

- Patients were supported to make decisions where appropriate and when they lacked capacity, decisions were made in the patient's best interests, recognising the importance of the person's wishes, feelings, culture and history.
- Staff understood and where appropriate, worked within the Mental Capacity Act definition of restraint.
- Staff knew where to get advice regarding Mental Capacity Act. Staff made Deprivation of Liberty Safeguard applications when required.
- The hospital had arrangements in place to monitor adherence to the Mental Capacity Act.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- We observed staff treating patients with kindness dignity and respect. This was confirmed by the majority of patients. One patient on Harlestone ward stated that staff did not always respond in a timely manner to patient requests.
- We saw a number of other caring interactions between staff and patients. We saw staff knocking on patient's doors, and staff talking to patients in a caring and respectful manner. However, we observed one staff member on Hawkins ward watching the television and not interacting with patients.
- Patients gave examples of how staff helped them, for example with their physical health needs and managing daily living skills such as cooking, cleaning and laundry.
- Staff had a good understanding of individual needs of patients and their behavioural support plans.

The involvement of people in the care they receive

- Staff orientated patients to the ward and service, as part of the admission process. This was supported by an easy to read welcome information pack, which patients were given on admission.
- Care records demonstrated that patients had been involved in their care plans and patients confirmed this. We saw evidence of this in patient care plans and from interviews with patients. However, we found that the care plans were not in an accessible format.
- Patients had access to an independent mental health advocate who regularly visited the wards.
- Carers had access to a support group. The provider invited carers to informal gatherings, for example, garden parties. There was a patient and carer's lead. The provider was planning to open a carer's hub in May 2018. Carers were invited to care programme approach meetings and care and treatment reviews.
- Patients were able to give feedback on the service they received in a number of ways and formats. These included multi-disciplinary meetings, one to one time with care coordinators, daily planning meetings, patient community meetings and surveys. The provider completed an annual patient experience survey. This was distributed via wards. Patients were encouraged to feedback via an opinion site on the internet.
- The Men's service had a patient group, chaired by a patient. This group reviewed patient feedback and complaints to pick up any themes. One theme identified was that some patients had not had a care review for over a year. The group took action to address this, which included contacting commissioners. A patient led group was involved in auditing care plans. A patient sits on the reducing restrictive practice group. Patients sit on the panels for recruitment and there is a patient panel at staff inductions.

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

(for example, to feedback?)

Requires improvement

Access and discharge

- Managers submitted data that evidenced bed occupancy over the last six months in the learning disability and autism pathway was an average of 85%. Therefore, beds would be available to admit patients when required.
- Patients were discharged or transferred back to their local area whenever this was practicable. Managers had regular meetings with commissioners and providers in the patient's local area in order to help facilitate appropriate discharge.

Requires improvement

Wards for people with learning disabilities or autism

- There was an average of a 90 day wait for a bed at this service. The provider attributed this to the fact that approximately 75% of patients admitted to this service are subject to a forensic section of the Mental Health Act with Ministry of Justice restrictions. The provider attributes the delay to the national lack of beds and delays in awaiting Ministry of Justice approval for transitions and admissions.
- Patients were not moved between wards during an admission episode unless this was justified on clinical grounds and in the interests of the patient.
- Managers and staff ensured that when patients were moved or discharged this was planned and happened at an appropriate time of day.
- Patient discharges were not delayed for other than clinical reasons. This was usually related to delays transferring patients back to their home area. In the last six months, there had been two delayed discharges from the service.
- Staff documented within patient care plans the identified section 117 aftercare services, to be provided for those who had been subject to detention under Section 3 or equivalent Part 3 powers of the Mental Health Act.

The facilities promote recovery, comfort, dignity and confidentiality

- Wards had access to a range of rooms and equipment to support treatment and care. These included sensory rooms, gym, swimming pool and library.
- Wards had quiet areas on the ward and a room where patients could meet visitors.
- Patents had access to a payphone on each of the wards
- Patients had access to outside space and gardens with staff supervision, due to their level of risk.
- Patients told us that the food was of a good quality and that there was a good range of menus.
- Patients were able to have supervised access to have drinks and snacks.
- Wards had single rooms with en suite facilities. Staff advised that patients were able to personalise bedrooms, however we saw limited evidence of this.
- Patients had keys to their rooms on upper Harlestone and Watkins house. In other wards patients had somewhere secure to store their possessions.
- Patients had access to a wide range of activities on all wards including at weekends. During the inspection, we observed patients accessing a wide range of activities. The wards had a range of rooms to support treatment and care such as an activity room and an activities kitchen. At Garden Cottage and Watkins House, patients accessed activities off the ward, including work based opportunities and were able to prepare their own meals.
- Patients did not always have access to activities and escorted leave. Seventy percent of patients interviewed stated that due to staffing shortfalls identified across all wards in the learning disability service, access to activities and escorted leave were frequently cancelled. Staff confirmed activities could not always take place as planned when staffing levels were low.
- Patients on upper Harlestone were participating in a five-kilometre run on the day of inspection, to promote health and wellbeing.

Meeting the needs of all people who use the service

- The service had suitable adjustments for people requiring disabled access.
- Patients had access to information leaflets, which were available in other languages for patients for whom English was not their first language. Information was also available in easy read format.
- Patients had access to a range of accessible information leaflets on treatments, patients' rights and how to complain. There was access to interpreters and signers where required.
- Patients had access to food to meet religious and cultural needs.
- The provider had a chaplaincy services and patients told us there was good access to appropriate spiritual support, for patients from all faiths.

Listening to and learning from concerns and complaints

- The learning disability and autism wards had received 16 complaints in the 12 months prior to inspection. The highest number, (six) were received by Harlestone, followed by Hawkins with five complaints. Three complaints were upheld and no complaints were referred to the ombudsman. The main themes related to staff attitude and communication.
- Patients knew how to complain and were supported to do so by staff. Overall, patients told us when they had complained, they had received feedback. However, one patient reported they had not received any feedback for six months.

Requires improvement

Wards for people with learning disabilities or autism

- Staff knew how to handle complaints. Staff received feedback from outcomes of complaints via e-mails and discussed in handovers.

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

Requires improvement

Vision and values

- The hospital values of compassion, accountability, respect and excellence were known and understood by staff.
- The objectives of the service reflected the organisational values,
- Staff reported poor visibility of senior management. Forty percent of staff told us that they did not know who the senior managers in the organisation were and they had not seen them on the wards.

Good governance

- Data provided showed overall mandatory training rates for staff were 95%, and managers had implemented a rolling training programme, which was in place at the time of inspection.
- Annual appraisal rates were 87% and staff received regular clinical and management supervision, with completion compliance at 92%. Managers had oversight to ensure these were completed.
- Managers ensured that where possible staff vacancies were covered through the use of bank or agency contracts to maintain continuity for patients. However, some shifts remained unfilled.
- Managers advised that clinical audits were undertaken mainly by staff external to the wards. These included medication, infection control, clinical notes and case tracking. Managers had not identified gaps in the recording of physical health monitoring. The majority of staff we spoke with did not know the outcomes or action plans from audits.
- Managers ensured that staff adhered to safeguarding, and Mental Capacity Act policy and procedures. However, on inspection we found gaps in Mental Health Act procedures in relation to recording.
- Managers fed back the outcomes of complaints and incidents in handovers, staff meetings and via staff bulletins.
- Managers addressed staff performance issues and offered support to staff in a supervisory role to address issues.
- The service had a range of targets, which were collated in the form of a performance dashboard.
- Managers had sufficient authority to undertake their role and had part time administrative support.
- The wards had a risk register to highlight risks within their service. Managers reviewed and updated the register in consultation with staff.

Leadership, morale and staff engagement

- The sickness and absence rate across the service was five percent.
- There were no bullying and harassment cases under investigation at the time of the inspection, although one staff member raised the issue of an oppressive culture within the service.
- Staff were aware of the provider's whistleblowing policy and reported to be confident to raise concerns without fear of reprisals. We reviewed six whistle blowing cases from May 2017 to February 2018. Of these, two were upheld, three were partially upheld and one was on going. All of the concerns raised in these cases came through the providers 'safe call' system. This is a confidential telephone and email system provided by an independent organisation for staff. Managers had investigated all whistle blowing cases within required timeframes.
- Morale at the service was variable. Seventy-five percent of staff expressed concerns about the understaffing on the wards. However, staffing on Mackaness ward and Watkins House was less frequently an issue.
- There had been no manager on Harlestone for a number of weeks. Managers had arranged interim cover; however, this was shared with another area, and was not adequate to cover the needs of the service. This had resulted in a lack of leadership and increased levels of stress for staff.
- Managers and staff had good leadership training opportunities. We found that career progression was encouraged. Advanced clinical practice modules were available via a local university. There were leadership development opportunities, including accredited

training for new and aspiring managers, full leadership programmes for nurse managers and operational leads and training for senior clinicians to become approved clinicians.
- Staff had opportunities for career development, including support workers being offered the chance to train as nurses. The provider had a rolling recruitment programme.
- We found evidence of good team working on Mackaness. We found that staff on Harlestone ward felt unsupported. On the day of inspection upper Harlestone had one registered nurse instead of two.
- Staff were aware of their Duty of candour and were open with patients if something went wrong.
- Staff told us that they could offer feedback on the service during team meetings and supervision.
- Staff held handover meetings twice a day where they could share information and raise any patient issues.
- Staff did not have access to regular team meetings on two out of five wards. However, staff felt they were informed of changes to the service via emails and handovers.

Commitment to quality improvement and innovation

- Staff on Mackaness ward ran an autism awareness event the day prior to inspection. We received positive feedback from both staff and patients.
- The service was preparing for the Autistic Spectrum Disorder quality network.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that seclusion medical and nursing reviews take place in line with the Mental Health Act code of practice.
- The provider must ensure the comprehensive care planning and recording of seclusion and practice.
- The provider must ensure all patient areas are assessed for ligature risks and blind spots and that these risks are mitigated.
- The provider must ensure that the premises and equipment are clean and maintained in a timely manner to ensure they are safe for patient use.
- The provider must ensure that ward environments and staff comply with the necessary requirements to meet fire safety standards.
- The provider must ensure that all medical equipment is checked.
- The provider must ensure that staff do not leave items on the ward that pose a risk to patients.
- The provider must ensure the comprehensive recording of patients observation including the rationale for observation and the times and details of observations.
- The provider must ensure the timely and comprehensive recording of medication administration.
- The provider must ensure staff update all risk assessments consistently in line with changes to patients' needs or risks.
- The provider must ensure that patients' physical healthcare needs are met in line with care plans.
- The provider must ensure there is sufficient out of hour's medical and physical healthcare support to meet patients' needs.
- The provider must ensure that there are sufficient staff at all times, to provide care to meet patients' needs, including taking section 17 leave and attending planned activities.
- The provider must ensure staff receive regular clinical and managerial supervisions.

Action the provider SHOULD take to improve

- The provider should ensure that opened food is labelled, indicating the date it should be consumed by.
- The provider should ensure that all eligible staff complete level 3 safeguarding training.
- The provider should ensure incidents are reviewed in line with their policy.
- The provider should ensure that care plans are available in an accessible form, for example in pictorial form for those patients who do not want or are unable to understand a lengthy paper document.
- The provider should ensure they provide patients and their carers with information to help orientate them to the ward as part of the admission process.
- The provider should ensure care plans on the long stay/rehabilitation wards are rehabilitation focused with patient input.
- The provider should ensure they provide a range of activities for patients to engage in.
- The provider should ensure access to a full range of rooms and equipment.
- The provider should ensure no blanket restrictions are in place.
- The provider should review the outside courtyard at Cranford ward as it was stark and bare.
- The provider should ensure that the dignity of patients is upheld when providing personal care.
- The provider should ensure that all staff know who senior managers are.
- The provider should ensure all wards receive sufficient management support.
- The provider should ensure that regular staff meetings take place on all wards.
- The provider should ensure that they consult staff and assess the impact of changes to staff roles prior to them being implemented.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that medical and nursing staff completed seclusion reviews as required in line with the Mental Health Act code of practice and that staff fully completed seclusion documentation. We identified three blind spots in seclusion facilities on the forensic and learning disability wards. The provider had not included the secret garden area for the forensic service on the ligature risk assessment. On Foster ward staff were unaware of the ligature risk audit. The audit was incomplete and did not include all rooms. The provider had not ensured all medical equipment was regularly tested to ensure it was in working order. On upper Harlestone ward, we found staff had not regularly tested the oximeter and blood pressure machine. The provider had not ensured that patients physical healthcare needs were met in accordance with care plans. There was no out of hours physical health care provision on site. The provider had not ensured that all risk assessments and care plans were in place, and updated consistently in line with changes to patients' needs or risks. Staff had not created personal emergency evacuation plans for patients on the older adults wards. Staff had limited access to specialist equipment for moving patients with limited mobility down stairs in the event of a fire. The lift was out of order which posed a risk to patients with limited mobility in the event of a fire.

This section is primarily information for the provider

Requirement notices

We found a roll of large orange plastic bags on a shelf in the corridor area on Foster ward. Plastic bags were not allowed on the wards as they presented a risk to patient's safety.

Staff had not followed safe procedures for the recording of medicines administration.

The activity kitchen on Prichard ward was dirty with flaking paint on the window sill and the laminate coating had come away from the worktop proving an infection control and food hygiene risk.

The environment on the older adults wards needed redecorating and refurbishing. The ward and one bedroom had an underlying unpleasant smell. Curtains were hanging off the rail in the main lounge area. Paint was peeling in the dining area.

There was a burst pipe in the kitchen that had burst previously. A bucket was placed underneath to catch the water.

We found equipment which had passed its expiry date or safety testing date in 2016.

There were exposed electrical cables behind the door leading to staff offices.

Handrails were not in place to enable patients at risk of falls to move around the wards more safely.

Staff lacked understanding of some of the risk issues.

This was a breach of regulation 12.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Managers had not ensured that all patients requiring observation or seclusion had appropriate care plans. There were gaps in the recording of observations. This meant that staff were not always aware of the rationale for the observation or seclusion and therefore may not

This section is primarily information for the provider

Requirement notices

be aware of the risks to patients and staff. If staff were not aware then patients could possibly act in ways which staff were not prepared for causing a risk to themselves or others.

Managers had not ensured good governance regarding the safe administration of medication. Electronic medication charts were signed after the medication round had finished rather than after each individual administration. This made it more likely that medication errors may arise.

The provider had not ensured all areas of the service met appropriate standards of cleanliness.

This was a breach of regulation 17.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that there were sufficient staff at all times to provide care to meet patients' needs. Not all staff had received regular clinical and managerial supervision over the 12 months prior to inspection. This was a breach of regulation 18.