Avesbury House

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Avesbury House **Good** overall because:

- Following our inspection in August 2015, we rated the service as good for effective and caring. We rated the service as requires improvement for safe, responsive and well led.
- During this inspection, we found the service had made considerable progress since the previous inspection in August 2015 but in some cases the improvements were not yet fully completed or embedded. There were some areas where we have asked the service to do some further work and some new areas for improvement have been identified.
- At the last inspection, in August 2015, there were no systems in place to handle complaints at the service. During this inspection we found there had been improvements. Patients knew how to complain. The service had a formal complaints system in place and staff were investigating complaints appropriately.
- At the last inspection, in August 2015, there were no systems in place to ensure records were complete, accurate and up to date. At the inspection this had improved. The manager could access key performance monitoring information easily in order to understand the performance of the team and make improvements in the service
- At the last inspection, in August 2015, we found that he service had not submitted all required statutory notifications to the CQC. At this inspection, we found that the service was regularly submitting notifications to the CQC when appropriate.
- Patients' risk assessments were regularly updated, comprehensive and personalised. Staff completed physical health assessments of patients on admission and on-going monitoring was robust. Staff had a good understanding of patient's individual needs.
- Staff used de-escalation techniques to calm any aggressive behaviour. Staff knew how to report safeguarding concerns and what to report. The service had introduced a new incident reporting tool which staff used with ease.
- Staff operated an effective and well-maintained medicines management system.
- The service had a full range of multi-disciplinary staff available due to the joint working with an NHS trust.

However,

- At the last inspection in August 2015 we found that the service did not have a ligature risk assessment in place and that staff were not aware of ligature risks and how to manage them. During the inspection, although this had improved, we found that ligature risk assessments did not identify all ligature points in the service, which meant that staff were unaware of the risks and how to mitigate them.
- At the last inspection, in August 2015, staff did not have a good understanding of the Mental Capacity Act. During the inspection, we found that this had not improved. Staff had little understanding of the Mental Capacity Act and its principles.
- Safeguarding vulnerable adults training for staff was low at 61%. Staff supervision notes were not always recorded appropriately.
- Staff did not provide all patients with copies of their care plans.

Summary of findings

Contents

Good

Avesbury House

Services we looked at

Forensic inpatient/secure wards

Summary of this inspection

Background to Avesbury House

Avesbury House is provided by Partnerships in Care 1 Limited. The provider took responsibility for the service in December 2016.

The service provides a 24 hour low secure service to male patients with severe and enduring mental health needs, often with a forensic history. It has 24 beds across five units. The service provides step down accommodation for patients coming from medium and high secure units at a local hospital forensic service.

At the time of our inspection there were 24 patients, all of whom were detained under the Mental Health Act.

NHS England contracts the beds at Avesbury House. NHS England commissioned the North London Forensic Service at Barnet, Enfield and Haringey Mental Health NHS Trust to provide the forensic multi-disciplinary team. The North London Forensic Service subcontracts to Avesbury House to provide the building, nursing staff, security staff, domestic staff and support workers.

This service is registered with the CQC to provide the following regulated activities:

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

At the time of this inspection there was a registered manager at the service.

Our inspection team

The team that inspected the service comprised two CQC inspectors, one pharmacist inspector, one consultant psychiatrist with a background in forensic services and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using inpatient services.

Why we carried out this inspection

When we last inspected this service in August 2015, we rated it as requires improvement overall.

We rated this service as requires improvement for safe, responsive and well-led. We rated the service as good for effective and caring.

Following the August 2015 inspection, we told the provider it must make the following actions to improve the service:

- The provide must ensure that there is an up to date ligature assessment for each independent living area and that all staff are aware of ligature risks and how to manage them
- The provider must ensure that systems are in place to ensure records are complete, accurate and up to date, including patients care records, risk assessments, staff rotas, staff supervision, training records and community meeting minutes
- The provider must ensure that there is a system in place to identify, receive, record, handle, respond to and learn from complaints.
- The provider must ensure they submit all required statutory notifications to the CQC

These related to the following regulations under the Health and Social Care Act) Regulated Activities) Regulations 2014:

Regulation 12 safe care and treatment

Regulation 16 receiving and acting on complaints

Regulation 17 good governance

Regulation 18 notification of other incidents

At this inspection we followed up the actions we asked the provider to make at the last inspection.

Summary of this inspection

How we carried out this inspection

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

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

During this inspection, we focused on those issues that had caused us to rate the service as requires improvement for safe, responsive and well led in August 2015. This inspection was also a full comprehensive where we looked at all five key questions.

We informed the provider two days before we visited the site that we were carrying out an inspection of the service.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 11 patients who were using the service
- spoke with the registered manager
- spoke with 10 other staff members; including doctors, nurses, occupational therapist, psychologist and social worker
- spoke with an independent advocate
- attended and observed one hand-over meetings and one multi-disciplinary meeting
- looked at 10 care and treatment records of patients
- carried out a specific check of the medication management at the service
- 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 10 patients at the service. Most patients said they felt safe on the ward. Patients felt able to raise complaints with staff. They told us that staff were caring and listened to them. Patients said that the majority of staff treated them with respect and that they always knocked before coming into their bedrooms. We received mixed feedback from patients about their care plans. Some said that they received a copy and understood their care plan whilst others said they had not seen a copy of their care plan. Patients we spoke to said they had been read their rights under the MHA regularly.

Patients took part in a patient satisfaction survey in March 2016. Over half of patients felt that they were involved in their care plans. Fifty seven per cent of patients said that staff spent enough time with them on their care plan. Fifty seven percent of patients said they felt listened to and 21% of patients said they did not feel listened to.

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:

- The service had not completely addressed the issues that had caused us to rate safe as requires improvement following the August 2015 inspection.
- At the last inspection, in August 2015, we found that the service did not have a ligature risk assessment and staff were not aware of ligature risks and how to manage them. During the inspection we found this had improved. However, ligature risk assessments did not identify all ligature points present at the service. This meant that staff could not ensure that the risks were managed effectively.
- Safeguarding vulnerable adults training for staff was low at 61%.

However:

- Patients' risk assessments were regularly updated and comprehensive. Staff knew what and how to report safeguarding concerns. The service had introduced a new incident reporting tool which staff completed. Staff used de-escalation techniques to calm any aggressive behaviour.
- The service's medicines management was well maintained and staff used effective systems to safely administer medication.
- At the last inspection, in August 2015, we found that searches were not based on risk assessments as stated in the provider's policy. During the inspection we found that searches conducted on patients returning from leave were carried out based on individual risk assessments.
- At the last inspection, in August 2015, we found that blind spots on the ward had not been mitigated. During the inspection we found that the service had recently installed closed circuit television to reduce blind spots and make the ward safer.
- At the last inspection, in August 2015, we found that not all staff had access to personal alarms. At this inspection we found that all staff had access to personal alarms.
- At the last inspection in August 2015, we found that staffing levels were low at the weekend and sometimes during the week. During this inspection, we found new staff had been recruited and the service had introduced a safer staffing tool, to calculate the numbers on each shift needed to make the ward safe for patients.

Summary of this inspection

Are services effective?

Good

We rated effective as **good** because:

- Patients' care plans were comprehensive and personalised. Staff completed physical health assessments of patients on admission and the on-going monitoring of physical health was thorough.
- The service had a full range of multi-disciplinary staff available. Patients had access to psychological therapies.
- Staff had a good understanding of the Mental Health Act.

However,

- At the last inspection in August 2015, we found that staff did not have a good understanding of the Mental Capacity Act. During the inspection we found that this had not improved. Staff had little understanding of the Mental Capacity Act and its principles.
- The service did not record supervision in an appropriate way for some staff.

Are services caring?

Good

We rated caring as **good** because:

- Staff were empathic and respectful towards patients. Staff had a good understanding of patient's individual needs.
- The service worked closely with an Independent Mental Health Advocate to represent patients' voices.

However,

- Not all patients were provided with a copy of their care plan.

Are services responsive?

Good

We rated responsive as **good** because:

- The service had addressed the issues that had caused us to rate responsive as requires improvement following the August 2015 inspection.
- At the last inspection, in August 2015, there were no systems in place to handle complaints at the service. During the inspection we found that this had improved. The service had a formal complaints system in place and staff were investigating them appropriately. Patients knew how to complain.
- At the last inspection, in August 2015, we found that discharge plans were not put in place where appropriate. During the inspection we found that this had improved. Staff completed discharge plans for patients when they were ready for move on.

Summary of this inspection

- At the last inspection, in August 2015, we found that patient feedback raised in community meetings was not being addressed in a timely manner. During the inspection, we found that patient feedback was being followed up by staff and action taken where appropriate.
- At the last inspection, in August 2015, we found that patients whose first language was not English were not always appropriately supported. During the inspection, we found this had improved. The service had contracted a language line for patients who needed interpretation services.
- Staff provided a range of activities for patients.

Are services well-led?

Good

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

- The service had addressed the issues that had caused us to rate well-led as requires improvement following the August 2015 inspection.
- At the last inspection, in August 2015, there were no systems in place to ensure records were complete, accurate and up to date. At the inspection we found this had improved. The manager could access key performance monitoring information easily in order to understand the performance of the team and make improvements in the service
- During the last inspection, in August 2015, some staff said they did not feel confident raising concerns and were fearful of victimisation. During the inspection we found this had improved. Morale amongst staff had improved and staff now felt able to raise concerns.
- At the last inspection, in August 2015, we found that there was no joint service level agreement between the local NHS trust and provider. During this inspection, we found the provider had a contract in place with the local NHS trust setting out the clinical responsibilities of the service and the NHS trust.
- Local senior management visited the teams and staff knew of them.
- The service had a risk register to assess and monitor risks and risk management at a service level.
- At the last inspection, in August 2015, the service was not submitting notifications to the Care Quality Commission. During the inspection we found the provider had notified the Care Quality Commission of incidents appropriately.

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.

Staff had training on the Mental Health Act (MHA). During admission staff explained patients' rights to them under the MHA. These rights were discussed with patients every three months or after significant dates, such as the renewal of their detention.

Section 17 leave was appropriately authorised and recorded on standardised forms. Conditions of leave were clearly stated and corresponded to relevant Ministry of Justice conditions for patients' leave.

Mental Capacity Act and Deprivation of Liberty Safeguards

Seventy four percent of staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). However, we found that staff did not have a good understanding of the MCA. Staff's knowledge of the MCA and its fundamental principles was minimal. Capacity assessments were often undertaken by the consultant psychiatrist. Where appropriate capacity assessments were completed.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- Avesbury House was a low secure service consisting of an air lock at the entrance and dedicated security staff. The building had four units, each containing four or five beds.
- At the last inspection, in August 2015, we found that blind spots on the ward were not mitigated. During the inspection we found this had improved. There were blind spots throughout the units where staff could not always view patients from communal areas. There was a dedicated security worker who completed hourly checks on patients and the environment. The service had recently installed closed circuit television cameras to reduce blind spots.
- At the last inspection, in August 2015, we found that the service had ligature points in the building but did not have a ligature risk assessment in place that identified the risks and enabled staff to manage them appropriately. Staff could not locate this at the last inspection. During the inspection we found staff completed a ligature risk assessment for the building once a year. However, we found that not all ligature risks were identified on the risk assessment. For example, a metal hook on a bathroom door was not on the ligature risk assessment. A pipe bend, which could be used as a ligature anchor point, in a flat, was not on the risk assessment. There were door closers on most doors, which could be used as ligature anchor points that were also not identified on the risk assessment. Staff said that that the service had started ligature reduction works a month before the inspection. There had been no incidents of self-harm at the service in the last 12 months and patients were assessed as low risk for self-harm.
- In addition, staff carried out a monthly environment health and safety check. This included a check of the ligature risks in each living unit. We looked at the checks from the last three months. This was not very detailed and did not identify ligature risks in the communal areas. The level of risk was rated at different levels for the same ligature points identified. For example, a tap in one unit was rated as a low level of risk and medium in another unit. The action plan included 'work in progress' for every ligature risk. Staff could not be sure that they were addressing these risks appropriately and in a timely manner. This posed a risk to patients.
- The service had ligature cutters available in the event of an emergency and staff knew where these were located.
- The clinic room was clean, well-organised and had hand washing facilities and space to prepare doses of medication. Medicines were stored securely in locked cupboards within the locked clinic room. Emergency medicines were tamper proof with the expiry date clearly visible on the front of the box. Staff had access to appropriate emergency medicines such as naloxone and adrenaline. Staff checked medical equipment daily for cleanliness and expiration dates. Staff also checked the medicines fridge and room temperature readings each day and these were satisfactory. Equipment for immediate life support such as, oxygen and ligature cutters was also stored in the clinic room and checked regularly to ensure they were in correct working order and in date.
- The ward environment was visibly clean and there were domestic staff onsite. The service had a number of

infection control policies and procedures. Staff carried out monthly health and safety audits. Audits carried out over the last three months included fire prevention, hygiene, outside areas, electrical equipment and kitchen areas. Staff checked these areas and any maintenance or cleanliness issues that were identified were reported.

- At the last inspection, in August 2015, we found not all staff had access to personal alarms. During this inspection, we found this had improved. There were nurse call points throughout the unit. Staff carried around personal alarms with them and these were working. Staff had a swipe card to get into the main building and a fob key for secure areas once inside.
- Staff kept records of the food fridge temperatures in the flat kitchens and these were within the appropriate range. Staff monitored food fridge temperatures to make sure they are the correct temperature to keep food fresh for patients and prevent food poisoning.

Safe staffing

- The service had established staffing levels of two nurses and three healthcare assistants for each day shift. On the night shift two nurses and two healthcare assistants worked together. Each shift had a qualified nurse.
- The service had one nurse vacancy at the time of the inspection. This was for a specialist learning disability nurse. The manager was in the process of recruiting to this post and hoping to fill it soon.
- The service used bank staff to fill vacant shifts. They worked regularly on the unit. The manager could use bank staff when staffing levels needed to be increased on the unit. For example, to increase levels of patient observation.
- The service used a safer staffing tool to collate data on the staffing levels for each shift. We looked at the tool and staff rotas for the last three months. Each shift was rated, red, amber or green based on whether the shift was full or short staffed. This monitored any unsafe staffing numbers on a shift. Staffing numbers were also recorded on a staffing rota. At the last inspection, in August 2015, we found that there was not enough staffing on the weekends. At this inspection this had improved. We looked at the rota for the month of February 2017. Weekend shifts had been filled and where needed bank staff filled extra shifts. The support staff had a copy of a rota which the senior nurse completed. Any staffing gaps on the rota were followed up in a paper diary for bank staff to write down their availability to cover a shift.
- Patients and staff we spoke with said that leave was rarely cancelled due to short staffing. In the last 6 months no leave was recorded as being cancelled for this reason.
- The ward had full time medical cover Monday to Friday provided by a speciality doctor and two consultant psychiatrists each working part time. Out of hours and at weekends the service could contact the consultant from a local hospital and staff said this worked well.
- We looked at seven staff records during the inspection. All staff had a completed disclosure and barring check carried out when they commenced employment.
- Mandatory training for staff included safeguarding vulnerable adults and children from abuse, breakaway, security, infection control and basic life support. The average rate for staff completing their mandatory training was 78%. Security training and safeguarding vulnerable adults training was relatively low at 67% and 61% respectively. Staff had been booked on blocks of training in the next few months. Staff also received medicines training via e-learning, and face to face training with the pharmacist.

Assessing and managing risk to patients and staff

- Patients were referred to the service from a local mental health NHS trust. The multidisciplinary team (MDT) already had a good understanding of the patient's risks. Nursing staff and the MDT jointly conducted a risk assessment when the patient was admitted.
- We looked at nine patient care records during our inspection. At the last inspection, in August 2015, we found that patient risks assessments were not up to date or accurate. During this inspection, we found this had improved. All of the records we looked at had up to date risk assessments completed on admission. The service used the historical clinical risk management tool. This is a specific tool used to assess and manage risk in people with a forensic history. The service had recently implemented a new electronic case management system which the MDT and nursing staff accessed. Staff updated risk assessments throughout the patient's stay. For example, after an incident with a patient a nurse updated their risk assessment and risk management plan.

Good

Forensic inpatient/secure wards

- Patient risk was discussed in the twice weekly ward round and the weekly forensic multidisciplinary team meeting. Staff had a movement board in the nurse's office on the unit which recorded and monitored patients leave. This was updated when leave was amended due to a change in risk.
- Staff did not restrain patients at the service. Staff used de-escalation techniques and had completed training for this. Staff told us they felt able to manage aggression without using restraint. Patients were not secluded whilst at the service as staff felt it was not necessary or appropriate. In the last 12 months there were no incidents of restraint at the service.
- The service had a procedure for observing patients. The procedure followed the National Institute of Care and Excellence guidelines for managing violence and aggression.
- Staff followed the service's policy when searching patients, either randomly or routinely. At the last inspection, in August 2015, we found that searches were not being carried out according to risk. During the inspection we found this had improved. Staff carried out monthly environment and personal searches to make sure that prohibited items, such as lighters or sharp objects, were not on the ward. Staff would also search patients or their rooms if there was a suspected risk. These searches were conducted by trained staff. The provider's policy stated that searches on formal patients could be carried out when they returned from leave. Informal patients were only searched with the patients consent. There were no informal patients at the time of the inspection.
- The service had started a restrictive practice assessment audit to reduce restrictive practices throughout the unit; it was on the agenda at clinical improvement groups and community meetings. Patients participated in this audit and identified practices such as access to the internet, phones, time of day to wake up, access to bedrooms and set bed times. Actions implemented included changing morning medication times to be more flexible according to individual needs. We saw good evidence from these audits where the patients were individually assessed as to what items they were able to have in their rooms depending on risk.
- Staff were trained in safeguarding adults from abuse and safeguarding children from abuse. However, these figures were relatively low at 61% and 57% respectively. Staff knew the safeguarding procedures and when to report abuse. The service had a safeguarding policy that staff followed. Staff kept a safeguarding log of every safeguarding incident at the service, detailing whether it was reported to the local safeguarding team and what type of abuse had occurred. Safeguarding incidents reported by staff included medication errors and patient on patient aggression. Three safeguarding incidents had been reported to the local authority by the service in the last 12 months.
- We reviewed 11 prescription charts. Medicines administration was recorded on prescription charts. All prescriptions included information relating to patient demographics and allergies. We saw evidence that a pharmacist had screened all inpatient prescription charts and had made appropriate clinical interventions. Doctors wrote up the prescription charts and conducted the initial medicines reconciliation for each patient admitted to the service. The pharmacist checked the medicines reconciliation at the next available opportunity. Medicines reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, or GP.
- Medicines for rapid tranquillisation were not used intramuscularly. Rapid tranquilisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. We were told that if a patient became unwell and required intramuscular rapid tranquilisation, they would be transferred to a different location. We saw minimal use of sedative medicines, which is sometimes required for patients who are agitated.
- Following the introduction of 'smoke free' across the service, patients who smoked had to leave the premises and smoke off site. Patients were not allowed cigarettes or lighters on the premises when they came back from leave. This meant they tried to hide their tobacco outside the premises and could not find it again; or they stored it at the local shop for a cost. As a result, staff bought lockers for the premises so that patients could store their tobacco securely when they came back from leave. Patients and staff said this was working well.
- Children were able to visit the premises to see their relatives. The service had an allocated area where children could visit relatives in a safe and private way.

Good

Forensic inpatient/secure wards

Track record on safety

- The service had reported two serious incidents in the last 12 months. These involved a medication error and a patient absconding from the unit. Both of these serious incidents were investigated by the provider.

Reporting incidents and learning from when things go wrong

- Incidents were a regular agenda item at the weekly multidisciplinary team meeting and reflective practice meetings. Staff reported all incidents on the service's electronic reporting system. Staff knew how to report and what to report.
- The service had reported 50 incidents in the last 12 months. Incidents included violence and aggression, security breaches and medication errors. We saw evidence of learning from incidents to improve the service. For example, a medication error occurred and as a result staff were given extra training and completed a medication competencies assessment.
- Staff had an opportunity to debrief after incidents, either through extra supervision or staff meetings. Incidents were a standard agenda item at monthly staff meetings.

Duty of candour

- The service had a duty of candour policy. Duty of candour is the need for professional healthcare staff to be open and honest when things go wrong for a patient in their care. Staff understood the importance of being open, transparent and apologising when things went wrong. For example, as a result of a staff error, a patient received the wrong medication. The service had apologised and identified what they needed to do to ensure that a similar incident did not occur again.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- All patients were referred to Avesbury House from the North London Forensic service as a step down in the forensic pathway. Patients came from high and medium secure wards at a local hospital. Prior to admission, the forensic MDT completed a comprehensive assessment of the patient and this was then handed over to the nursing team at the service. The staff at Avesbury House discussed the patients' needs and completed their own assessments. Patients could visit Avesbury House before admission to orientate themselves to the service.
- We looked at nine patients care records. The majority of these included care plans that were detailed and personalised according to the patient's needs. For example, we saw a patient's care plan which specified the support staff provided in relation to their physical health. The service had recently implemented a new electronic case management system so not all care plans had moved over to the new system. For example, we saw one care plan where a patient had specific physical and mental health needs, but did not have a care plan updated to reflect his new support needs.
- Patients' physical health was assessed on admission and there was on-going monitoring during their stay at Avesbury House. There was evidence in patient records of patients being referred to the GP for physical health assessments and of hospital admissions where appropriate. For example, a patient had recently returned from an inpatient stay at a general hospital.

Best practice in treatment and care

- We looked at nine patient care records and found that patients had physical health care plans where staff identified a need. Staff used the Lester tool to monitor patient's physical health. The Lester tool is a guide to assist staff in assessing the cardio metabolic health of people experiencing psychosis and schizophrenia. This enables staff to deliver safe and effective care to improve the physical health of patients.
- Staff assessed whether patients' needed support with smoking cessation. Those patients that wanted to stop smoking were supported with nicotine replacement therapies. Staff also assessed patients for whether they needed support for substance and alcohol misuse.
- A clinical psychologist was based at the service offering a range of psychological interventions. These included national institute of care and excellence recommended therapies such as cognitive behavioural therapy and psychodynamic therapy. The psychologist tailored interventions for patients who had been in hospital for a long time and may have become institutionalised.

- We saw evidence of staff using the health of the nation outcome scales to measure patients' health and social functioning. Staff could then assess the level of care that each patient needed.
- The pharmacist regularly audited the clinic room as well as the use of high dose antipsychotics, legal authorisations for treatment, allergy status, and clozapine stock. Staff received outcome data via the pharmacy contractor's electronic system. Staff also completed audits on restrictive practice and on patients' care plans.
- Doctors considered National Institute for Health and Care Excellence guidelines when prescribing medicines.
- The service used commissioning for quality and innovation (CQUIN) goals to demonstrate improvements in quality for specified areas of patient care. The service had a CQUIN for physical healthcare and restrictive practices. Staff collected data on health checks, physical healthcare in care plans and smoking cessation to drive improvement on monitoring patient's physical health.
- Staff worked with patients on their rehabilitation when they utilised their section 17 leave. For example, staff used a gradual approach with some patients leave. Patients would begin with escorted leave and gradually work towards unescorted leave. We saw evidence of patients using their leave to attend the gym, shopping, work experience and the mosque.

Skilled staff to deliver care

- The service had a full multidisciplinary team including consultant psychiatrists, social workers, psychologists, occupational therapists and a pharmacist.
- Nursing staff were registered with the nursing and midwifery council and their registration was up to date. Nursing staff were supported with their revalidation. This is the process that nurses who remain in practice need to go through to update their nursing registration.
- The nurse team leader supervised the nursing and support staff and the hospital manager supervised the nurse team leaders. The service had recently started keeping a spreadsheet of monthly staff supervision. We looked at the data from September 2016 to January 2017. Nursing staff received supervision each month since September. However, we could not find any supervision recorded for the team leaders. We asked for these supervision records from the manager. The records had been handwritten in the manager's notebook. The manager's notes taken of supervision with the team leader were brief. A copy of the supervision notes had not been given to the staff member. All seven of the staff records we reviewed showed that staff had received an annual appraisal in the last 12 months.
- Nursing staff attended reflective practice every month where they discussed clinical and management practices like medication errors, care plans and audits. These meetings were a forum for nursing staff to discuss their practice with each other and communicate in an open and honest way.

Multi-disciplinary and inter-agency team work

- The service worked with the multi-disciplinary team from a local hospital, which comprised two consultant psychiatrists, a social worker, occupational therapist and clinical psychologist. This MDT team worked jointly with the provider and was managed between an NHS trust and the provider. The service had an MDT meeting every week as well as a weekly ward round where staff discussed each patient.
- Staff handovers took place every shift. We attended a morning handover during the inspection. Staff discussed patient incidents, patient leave and general observations. For example, we heard that one patient had attended the hospital earlier that morning due to an accident at the service. The handover meant that staff could communicate each shift the level of risk and tasks that were happening each day.
- Staff liaised with patients' care coordinators regarding their care and treatment. Social workers attended the ward round and patients' care programme approach meetings. Patients registered with the local GP and staff encouraged them to attend for physical health checks. Patients told us that they attended the local GP as much as they needed.

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

- Seventy nine percent of staff had received training in the Mental Health Act (MHA). Staff had a good understanding of the MHA code of practice and how it worked in practice.
- Thirteen patients were detained under sections 37/41 of the MHA, which meant they had additional conditions of detention.

Good

Forensic inpatient/secure wards

- The service had a Mental Health Act administrator four days a week. The administrator offered advice to staff on the MHA and checked that patients' paperwork was up to date. They also kept up to date with patients' appeals and tribunal dates.
- The consultant completed consent to treatment forms on admission. From the patient care records we looked at we saw evidence that certificates of consent to treatment (T2) were completed on admission. We also saw certificates of a second opinion (T3) completed in patient records, when appropriate.
- Patients had access to an independent mental health advocate (IMHA) who visited the service every week. The IMHA facilitated the weekly community meeting with patients and also saw patients privately to discuss their rights under the MHA.
- Staff recorded when patients' rights were explained to them at regular intervals.

Good practice in applying the Mental Capacity Act

- Seventy four percent of staff had received training in the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS).
- At the last inspection, in August 2015, we found that staff did not have a good understanding of the MCA. During this inspection, this had not improved. We spoke with five staff members and they did not have a good understanding of the MCA. For example, staff did not know the five principles that underpin the Act or how to carry out a capacity assessment. Staff could not confidently apply the MCA in practice. Staff informed us that if a patient's capacity was queried then the consultant would carry out the assessment. We identified two patients that needed support with their personal care needs due to their cognitive impairments and therefore needed their capacity assessed. This is something that staff would be supporting patients with each day. This meant that patients could be receiving care and support without taken into account their best interests. However, we found that capacity assessments for patients' consent to care and treatment were completed where required these were only carried out by the consultant psychiatrist.
- There were no patients subject to a DoLS at the time of the inspection.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- We observed a ward round and saw staff speak to patients in a respectful manner. At the community meeting staff addressed patients in a caring way and discussed reducing restrictive practices. Throughout the inspection we saw staff speak to patients in a thoughtful and an empathetic way.
- We spoke with ten patients during the inspection and received general feedback on staff. Five patients told us they felt safe at the service and that all staff were caring. Some patients said that most staff would always knock before entering their room. Patients felt that staff listened to them and they could tell them about their concerns at the service.
- Staff understood the needs of the patients. For example, there was evidence of staff liaising with criminal justice agencies and welfare benefits agencies as a way of supporting patients. Staff also supported patients on leave to have more independence ready for when they move on.

The involvement of people in the care they receive

- Staff provided patients with a handbook about Avesbury House and orientated them to the service when they were admitted. Patients were given the opportunity to visit the service before their admission.
- We received mixed feedback from patients on whether they were involved in their care plans. Two patients told us that they were given copies of their care plans and were consulted on their care plans while four others told us they were not. Staff recorded on patients' care plans that they had received a copy. Staff discussed patients care and treatment with them at ward rounds.
- Patients had access to an independent mental health advocate (IMHA) once a week. An IMHA supports patients to understand their rights under the Mental Health Act. The IMHA facilitated the weekly community meeting.
- The unit had a separate room where families and carers could visit patients. Relatives and carers attended ward

rounds and care plan approach meetings where possible. This gave carers the opportunity to ask how to support the patient when they were discharged and have involvement in care planning.

- At the last inspection, in August 2015, we found that feedback from patients was not responded to in a timely manner. During the inspection, we found this had improved. A patient representative attended the monthly service clinical governance meetings. They fed back on the issues patients brought up in the community meetings. For example, patients fed back matters such as the use of mobile phones and the service user handbook format. Staff then addressed these issues within the patient community meeting and discussed the improvements that had been made.

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

(for example, to feedback?)

Good

Access and discharge

- A local NHS trust block purchased the beds at Avesbury House. The service was at full bed occupancy at the time of the inspection. The service was a step down low secure unit for men coming from medium and high secure services.
- Patients were able to visit the service to look around and orientate themselves to the service. Staff went to visit patients in the local hospital to complete an assessment on the patient after a referral was made.
- The average length of stay for patients was nearly three years. The most recent admission was this year. One patient had been at the service for over seven years. Most patients came from London boroughs.
- At the last inspection, in August 2015, we found that discharge plans were not put in place where appropriate. During this inspection, this had improved. There was one patient ready for discharge at the time of inspection as staff could no longer meet his needs. Staff described the difficulties of moving patients on due to the nature of their physical and mental health problems. However, the service had a clear transition plan in place for moving patients on and a dedicated discharge coordinator onsite. For example, once a patient was identified for discharge the process of referring to a local hostel started and a transition plan was implemented with the patient's involvement. Staff worked closely with the occupational therapist to prepare patients for move on and once discharged staff would visit the patient within the first 12 weeks.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had units consisting of an average of five beds. The units each had their own kitchen, communal dining and living space. As well as the units there was a large communal dining and living space for the whole hospital.
- Each patient had a key to their room. Staff had a swipe card to get into the main building and a fob key for secure areas once inside.
- The service had a garden area for patients. The garden was kept locked.
- The movement board in the nurses' office contained confidential patient information and was situated by the window overlooking a public walkway. The information was not covered so a member of the public passing or another patient could see this confidential information. We informed staff of this on the day of our visit and they sought to rectify this immediately.
- Patients' meals were provided and cooked by a chef employed at the service. Patients also received support from staff to cook food as part of developing their independent living skills. Patients gave mixed feedback on the quality of the food. This was because the service used agency chefs and this did not provide consistency. The food catered to various dietary requirements.
- Patients were able to make hot drinks and snacks in their unit kitchens at any time of the day and night. The oven was switched off after 8pm however for safety reasons.
- A payphone was present in the communal corridor for patients to make phone calls, but was not in a private area. This compromised patient confidentiality. However, after feedback from patients, staff provided individual patients with a basic mobile phone to make private phone calls.
- Activities were provided at the service throughout the week and at weekends. Activities included football,

shopping and cinema club. Patients had access to the local gym in the area which some attended. A dietitian attended the service once a week to promote healthy lifestyle.

Meeting the needs of all people who use the service

- The service had a multi-faith room, which was not in use during the inspection, as building contractors were storing their equipment in it. The manager assured us this would be rectified immediately. It contained prayer mats and information on various religions. Patients also used their leave to visit their places of worship
- The hospital was all on one level on the ground floor. Wheel chair users could access all areas on the site.
- At the last inspection, in August 2015, we found that staff did not engage appropriately with patients whose first language was not English. During this inspection we found this had improved. Interpreters were made available for people where English was not their first language. The service used a language line for short notice interpretation. This meant that non-English speaking patients could communicate and understand key information about their care and treatment. Whilst information leaflets were not available in other languages, we saw patient feedback from the clinical governance meeting describing that the service user handbook was in a clear language and a pictorial format.

Listening to and learning from concerns and complaints

- At the last inspection, in August 2015, we found that there was no system in place to raise complaints. During the inspection we found that this had improved. Patients told us they knew how to complain and felt able to give staff feedback. Information on how to complain was readily available. Patients raised complaints with a member of staff first. The manager then sent the patient an acknowledgement letter. The complaint was then investigated by a member of staff and an outcome letter sent to the patient.
- The service had received seven formal complaints in the last 12 months. Three of these complaints were upheld. The service kept a register of the formal complaints received and the stage of investigation they had reached. This meant that patients had a formal way of raising concerns. Themes of complaints included medication side effects, staff support, meals and maintenance issues.
- Informal complaints were raised at the weekly community meeting. For example, we saw patients raising issues with staff about their wash basins and staff stating they would address the concerns.
- The service gathered feedback from patients through the weekly community meetings and also from surveys. We saw a recent survey that had been completed by patients regarding the food on the unit. Patients were able to inform staff about what food choices they liked and also their dietary requirements. Patients discussed issues such as catering and relational security with staff at the community meetings.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- A new provider had taken over the service of Avesbury House in December 2016. The new provider had not yet fully implemented any changes such as their vision and values. Policies and systems had not yet changed over to the new provider.
- The service director visited the unit regularly, as they line managed the hospital director. Staff knew who they were.

Good governance

- At the last inspection, in August 2015, the service did not have systems in place to monitor staffing levels, supervision, mandatory training, patient feedback and complaints. During the inspection we found this had improved. The manager and senior nurses used a tool to monitor levels of safe staffing on each shift. All complaints were kept on a tracker with the description, investigation timescales, what action was taken and the outcome. This meant the service could monitor each complaint and use the information to improve the service. Staff supervision was recorded on a spreadsheet, which management used to keep track of monthly supervision.

Good

Forensic inpatient/secure wards

- The forensic MDT was governed by the policies and procedures of the local mental health trust, who was their employer. However, whilst at Avesbury House the forensic MDT were subject to all service level policies and procedures when carrying out their roles and responsibilities. At the last inspection, in August 2015, we found no joint service level agreement between the local NHS trust and provider. During the inspection we found the service had a contract in place for 2016/17 between the local NHS trust and the provider. This outlined the clinical arrangements, contract management and operational standards at the service. This created a joint way of working and formalised both provider's roles and responsibilities at the service.
- The service had a risk register. The risk register monitored and assessed risk at a service level. We looked at the risk register dated October 2016. Sixteen risks were identified on the register including, ligature risks, patients absconding and the number of security keys used by staff. The register outlined how staff reduced these risks. For example, the service had started anti-ligature works and security fixtures on the building in January 2017. The key management for staff had been reduced to include a fob key and a swipe card.
- The service held monthly clinical governance meetings attended by service staff and staff from the local trust. A patient representative also attended and gave feedback about the service. We reviewed the minutes for the meetings for the last six months. Each meeting had a standard agenda including learning from incidents, complaints, audits, and staffing and searches.
- At the last inspection, in August 2015, the provider was not submitting notifications to the Care Quality Commission (CQC). During the inspection, we found this had improved. Notifications had been sent to the CQC by the provider regarding incidents and safeguarding concerns. For example, a safeguarding referral made by staff regarding a patient in October 2016 had been submitted to the CQC.

Leadership, morale and staff engagement

- The service had employed three different managers in the last 12 months. The manager had been at the service since June 2016. This had provided some stability amongst the nursing and support staff. However, the manager and service director explained that they were both leaving the organisation in April 2017.
- At the last inspection, in August 2015, the provider did not have adequate processes in place for staff to report bullying and harassment. During this inspection, we found improvements. The provider had recently changed as had the management team. Staff recognised that the change in management had affected the smooth running of the service, but that they had a strong team. The provider had a whistleblowing policy and staff were aware of this. The nursing staff said that they felt able to raise concerns with each other and were free from victimisation.

Commitment to quality improvement and innovation

- Avesbury house was part of the Quality Network for Forensic Mental Health Services. This is a multidiscipline approach to quality improvement on low and medium secure forensic wards through sharing best practice.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that they identify all ligature risks in the service and staff are made aware of these. Plans must be put in place to mitigate these risks.

Action the provider SHOULD take to improve

- The provider should ensure that all staff complete mandatory training, especially safeguarding vulnerable adults and safeguarding children training.
- Staff should ensure that all patients are provided with a copy of their care plan to reference.
- The provider should ensure that staff on all wards have a clear understanding of the MCA and the implications for their practice.
- The provider should ensure that all staff receiving monthly supervision is recorded appropriately.

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 service users were receiving safe care and treatment. The ligature risk assessment for the service did not identify all ligature points. Consequently there were no plans in place to manage these risks and staff were not aware of them. This was a breach of regulation 12(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

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.