St Andrews Healthcare

St Andrews Healthcare - Essex

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

Overall rating for this service	**Good** 
Psychiatric intensive care units and health-based places of safety	**Good** 
Long stay/forensic/secure services	**Good** 

Summary of findings

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Summary of findings

Overall summary

Overall we found that improvements were required as the services provided were not always safe. Actions from ligature audits were not followed through on one ward and care and treatment records were incomplete in respect of one person's physical healthcare needs. This meant that people may be at risk of unsafe care and treatment.

There were systems in place to ensure an effective service. Surveys and audits measured the quality and effectiveness of systems.

The services provided were caring. This was confirmed by our observations of the care and treatment being provided and subsequent discussions with staff.

The services provided were responsive. Evidence was seen that demonstrated to us that the provider encouraged feedback from people and staff to influence the running of the service.

The services provided were well led. Most staff told us that they felt supported. Staff across all of the wards inspected told us that there were difficulties with the recruitment and retention of staff. We found that there was widespread use of bureau (St Andrews healthcare staff) and agency staff on the wards inspected.

Easton Lodge

Maldon

Core service provided: Long Stay/forensic/secure services

Male/female/mixed: Female

Capacity: Six bed

Danbury

Core service provided: Long Stay/forensic/secure services

Male/female/mixed: Male

Capacity: 18 bed

Hadleigh

Core service provided: Long Stay/forensic/secure services

Male/female/mixed: Male

Capacity: 17 bed

Audley

Core service provided: Long Stay/forensic/secure services

Male/female/mixed: Female

Capacity: 18 bed

Easton Lodge

Core service provided: Long Stay/forensic/secure services

Male/female/mixed: Male

Capacity: Four bed

Frinton

Core service provided: Psychiatric intensive care unit

Male/female/mixed: Female

Capacity: 14 bed

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires Improvement

Overall we found that improvements were required as the services provided were not always safe. Actions from ligature audits were not followed through on one ward and care and treatment records were incomplete in respect of one person's physical healthcare needs. This meant that people may be at risk of unsafe care and treatment.

Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this. Staff received training in the management of violence and aggression. We found that restraint was used safely and only as a last resort.

We found staff reported any incidents/accidents and there was a system in place for reviewing and learning from them to prevent a reoccurrence.

Risk assessments and management plans were available for people and the environment to keep them and others safe.

Systems were in place to ensure adequate staffing and skill mix. For example, we found that the provider used a recognised tool for identifying people's dependency needs and the level of staffing required. Nursing staff rotas were planned four weeks ahead. However some concerns were identified across this location about the high use of bureau and agency staff on the wards.

We found that the wards were clean and staff practised safe infection control procedures to minimise the risk of cross-infection.

Are services effective?

Good

Outcomes for people were also assessed through use of the Health of the Nation Outcome Scale (HoNOS) secure assessment tool. A range of therapeutic interventions in line with National Institute of health and care excellence (NICE) took place.

We found effective multi-disciplinary working (MDT) within the service to meet people's needs. The location had clear procedures in place regarding their use and implementation of the Mental Health Act and the Mental Health Act code of ractice. Advocates were available to people throughout the hospital and most people we spoke with told us they were aware of their rights.

Summary of findings

Staff confirmed that they had received mandatory training and this was confirmed by those records seen. We found that staff had access to regular supervision and staff had received annual appraisals. We saw examples of additional training being provided for unit based staff

We received mixed feedback about the availability of activities at both locations however we saw systems were in place to monitor this. We found that some staff had difficulty in accessing the electronic care and treatment records used throughout the hospital.

Are services caring?

Good

Most people told us that staff were approachable and they gave them appropriate care and support.

The provider had systems to encourage people to be involved in their assessment, care planning and reviews through use of recovery tools such as 'My Shared Pathway'. People had the opportunity to attend a hospital based 'Service user forum'.

Are services responsive to people's needs?

Good

We saw evidence in people's care and treatment records of how the service had reviewed and amended treatments in order to meet their changing assessed needs. We reviewed some good examples of responsive care during the inspection.

A Quality Network for forensic mental health services, peer and self-assessment inspection had taken place on Frinton ward in May 2014 with identified good practice and areas for improvement. We noted that the provider had already taken actions to address an area identified for improvement.

There were opportunities for people to learn or maintain their skills and independence to the level they felt they were able to manage.

People's physical health needs were being appropriately monitored with regular checks completed. Chaplaincy information was displayed on wards.

Information about how to make a complaint was clearly displayed on the ward noticeboards for people to read. People told us that they felt well supported by staff in making complaints.

Complaints and concerns raised were discussed at the monthly 'Patient Safety and Experience Group' meeting to ensure that actions were completed and responses and feedback sent to people in a timely manner.

Summary of findings

There was evidence of site developments to respond to people's assessed needs. However there were not consistent systems for staff to respond to and meet people's diverse cultural and language needs on Frinton ward.

Are services well-led?

Good

We found that the provider provided information to staff and people about their service in different and effective ways. Most staff were aware of the provider's core values.

The provider had a governance framework in place at this location with links for feedback to/from the central site at Northampton. For example we noted that 'out of hours' visits by senior staff and unannounced visits from directors took place with reports on the quality and experience of care provided.

Most staff reported support from their manager. They told us they undertook training and had supervision, team meetings and appraisals to ensure they were competent and confident in their role. Most staff reported managers were approachable and they were effective leaders.

There was no manager in place for Danbury ward.

People and staff were encouraged to give feedback on the quality of the service in various ways such as meetings and surveys.

Summary of findings

What we found about each of the main services at this location

Psychiatric intensive care units and health-based places of safety

Good

Overall we found that PICU services provided safe, effective, caring, responsive and well led services.

We found that risk assessments were carried out to keep people, staff and the environment safe.

There were systems in place to ensure an effective service. Surveys and audits measured the quality and effectiveness of systems.

The services provided were caring. This was confirmed by our observations of the care and treatment being provided and subsequent discussions with staff.

The services provided were responsive. Evidence was seen that demonstrated to us that the provider encouraged feedback from people and staff to influence the running of the service.

The services provided were well led. Most staff told us that they felt supported. Staff across both wards told us that there were difficulties with recruitment and retention of staff. We found that both units used a number of bureau (St Andrew's healthcare staff) and agency staff to support people.

Long stay/forensic/secure services

Good

Overall we found that improvements were required as the services provided were not always safe. Actions from ligature audits were not followed through on one ward and care and treatment records were incomplete in respect of one person's physical healthcare needs. This meant that people may be at risk of unsafe care and treatment.

There were systems in place to ensure an effective service. Surveys and audits measured the quality and effectiveness of systems.

The services provided were caring. This was confirmed by our observations of the care and treatment being provided and subsequent discussions with staff.

The services provided were responsive. Evidence was seen that demonstrated to us that the provider encouraged feedback from people and staff to influence the running of the service.

The services provided were well led. Most staff told us that they felt supported. Staff across all of the wards inspected told us that there were difficulties with the recruitment and retention of staff. We found that there was widespread use of bureau (St Andrews healthcare staff) and agency staff on the wards inspected.

Summary of findings

What people who use the location say

We spoke with people who used these services provided by this provider through focus groups, attendance at community meetings, service user forum meetings and individual conversations with people. We reviewed the provider's quality monitoring systems such as surveys and monthly business continuity meeting minutes.

People told us that they felt safe on the wards and had good care. They said that staff listened to them and were good at defusing situations which helped people to feel safe.

We reviewed the results of recent satisfaction surveys carried out on Danbury and Frinton wards. Many of the comments seen were positive but some people requested more consistent staff and activity provision.

Most people told the inspection teams that staff were caring and understood them. They said that this helped them to trust the staff. Some people told us that activities that they enjoyed were offered. Whilst others told us that they wanted a wider range of activities provided.

Some people told us that the food provided was good. Food was prepared on site and people could choose from a menu.

Some people had concerns about accessing section 17 leave and felt that they were disadvantaged by some people requiring more staff time and attention due to the acuteness of their illness.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the ligature risks identified on Audley ward are risk assessed and addressed.
- The provider must ensure that all assessment and treatment records for people who use Maldon ward are accurate and fit for purpose.

Action the provider SHOULD take to improve

- The provider should ensure that the current refurbishment programme addresses the blind spot identified on the seclusion room on Audley ward.
- The provider should ensure that emergency resuscitation drills take place as part of ongoing staff training.
- The provider should review the effectiveness of their current staff recruitment and retention policy and procedures.
- The provider should ensure that the maintenance issues identified around the hospital's drainage system and excessively warm ward areas are addressed effectively for the comfort of people and staff.
- The provider should ensure that all staff have appropriate access to those electronic care and treatment records that they require to effectively do their job.
- The provider should review the current practice of blanket restrictions within this location. For example the locking of patient bedroom corridors at specific times.
- The provider should review the systems in place on Frinton ward for staff to respond to and meet people's diverse cultural and language needs.
- The provider should ensure that recruitment takes place to ensure that a ward manager for Danbury ward is appointed.
- The provider should ensure that every action plan detailing their response to direct people's feedback are available on the unit.

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice:

- We observed and staff reported good and supportive multi-disciplinary team working.
- Additional systems were in place to review enhanced support and seclusion/segregation, such as arranging for doctors across wards to give a second opinion/ independent review on the management of these incidents.
- Robust systems were in place for the management and auditing of medicines.
- We found that the monthly patient safety and experience group held at St Andrews Healthcare Essex was an effective forum for managing and learning from patient safety incidents that took place in the hospital.
- We identified good examples of the provider supporting staff to attend additional training to prepare them to care for people with specific mental healthcare needs.
- We found good examples of effective cognitive behaviour therapy taking place with individuals.
- The hospital director was providing effective and collaborative leadership to this location.

St Andrews Healthcare - Essex

Detailed findings

Services we looked at:
Psychiatric intensive care units and long stay/forensic/secure .

Our inspection team

Our inspection team was led by:

Our inspection team was led by:

Chair: Stephen Firn CEO Oxleas NHS Foundation Trust

Team Leader: Nicholas Smith Head of Hospital Inspection CQC

The team included CQC inspectors and a variety of specialist and experts by experience.

The team that inspected this location were a CQC hospital inspection manager, two CQC inspectors, a consultant psychiatrist, two specialist senior registered mental nurse advisors, three Mental Health Act reviewers, a specialist CQC pharmacy inspector and a senior social worker specialist advisor.

Background to St Andrews Healthcare - Essex

St Andrew's Healthcare is a charity providing specialist mental health care which was established approximately 176 years ago. The Charity provides services for adolescents and young adults, women, men and elders, with 1000 inpatient beds. Additionally it provides community and in-reach services, private therapy services for GP-referred patients and medico-legal expertise.

St Andrews Healthcare Essex is a low secure hospital located in North Benfleet, Essex. The hospital is registered to accommodate 92 adults who have mental illness and can be detained under the Mental Health Act 1983. Accommodation is on the ground and first floors. There is a separate step down unit, which was completed in April 2009.

The core services provided at this location were secure and forensic services and a psychiatric intensive care unit (PICU). We noted that the provider was refurbishing this location and in the meantime only six out of the seven wards at this location were being used.

On the day of our inspection there were 58 people receiving assessment and treatment in this service; 57 of these people were detained under the 1983 Mental Health Act. We found that that the informal person had agreed to stay in the step down service whilst an appropriate future placement could be found for them.

The provider had three outstanding compliance actions from previous Care Quality Commission inspections dated December 2013 and May 2014 for this location. The Commission had received a written action plan from the provider demonstrating how they would achieve

compliance with these relevant regulations. This had been updated regularly by the provider. As a result of this inspection; we found that the provider was now compliant with these regulations.

Why we carried out this inspection

We inspected this location as part of our comprehensive inspection programme of independent health care providers of mental health services. This provider was selected to enable the Care Quality Commission to test and evaluate its new inspection methodology across a range of different mental healthcare service providers.

How we carried out this inspection

St Andrews Healthcare Essex

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting this location, we reviewed information which was sent to us by the provider and considered feedback from relevant local stakeholders including advocacy services and focus groups.

We carried out an announced visit to this location on 10 and 11 September 2014. We spoke with 41 people who used the service. We reviewed 32 care and treatment records in detail and all relevant prescription charts.

We observed three location based activity sessions for people, a ward based community meeting and attended a location based morning planning meeting. This allowed the inspection team to learn about the day to day life of the hospital.

We held separate focus groups for people who used the service, senior and junior staff. We spoke to some family carers by telephone. This enabled the inspection team to get their views about this location.

A patient safety group meeting and three clinical reviews with the permission of people who used the service and staff were observed by members of the inspection team. This assisted the inspection team to learn about how the location managed clinical safety and involved individuals in their own assessment and treatment plans.

We spoke with 35 staff. This included four senior hospital managers, each ward based manager, 14 front line front line staff, support staff and three doctors including the lead responsible clinician (RC) for the location.

We also reviewed the provider's systems for obtaining feedback from other people who had contact with the service. This assisted the Care Quality Commission to obtain a view of the experiences of people who use the services.

The team would like to thank all those who met and spoke to the inspection team during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at this location.

Mental Health Act responsibilities

Information about the service

St Andrews Healthcare Essex is a low secure hospital located in North Benfleet, Essex. The hospital is registered to accommodate 92 adults who have mental illness and can be detained under the Mental Health Act 1983. Accommodation is on the ground and first floors. There is a separate step down unit, which was completed in April 2009.

The core services provided at this location were secure and forensic services and a psychiatric intensive care unit (PICU). We noted that the provider was refurbishing this location and in the meantime only six out of the seven wards at this location were being used.

On the day of our inspection there were 58 people receiving assessment and treatment in this service; 57 of these people were detained under the 1983 Mental Health Act. We found that that the informal person had agreed to stay in the step down service whilst an appropriate future placement could be found for them.

Summary of findings

Whilst almost all of the people who used the services at this location were currently detained under the Mental Health Act 1983. We saw that people's mental capacity to consent to their care and treatment had been assessed.

Those assessment and treatment records seen showed us that where people had been assessed as not having the mental capacity to consent to their care and treatment, decisions were made in their best interests. Most staff spoken with demonstrated an awareness of the Act.

Good

Psychiatric intensive care units and health-based places of safety

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

Information about the service

The twelve bedded psychiatric intensive care unit was being provided on Frinton ward at this location and was a female only service. During our inspection nine people were receiving assessment and treatment. Each person was detained under the 1983 Mental Health Act.

The provider had a total of four outstanding compliance actions from previous Care Quality Commission inspections across both locations. The Commission had received a written action plan from the provider demonstrating how they would achieve compliance with these relevant regulations. This had been updated regularly by the provider. As a result of this inspection we found that the provider was now compliant with these regulations.

Summary of findings

Overall we found that PICU services provided safe, effective, caring, responsive and well led services.

We found that risk assessments were carried out to keep people, staff and the environment safe.

There were systems in place to ensure an effective service. Surveys and audits measured the quality and effectiveness of systems.

The services provided were caring. This was confirmed by our observations of the care and treatment being provided and subsequent discussions with staff.

The services provided were responsive. Evidence was seen that demonstrated to us that the provider encouraged feedback from people and staff to influence the running of the service.

The services provided were well led. Most staff told us that they felt supported. Staff across both wards told us that there were difficulties with recruitment and retention of staff. We found that both units used a number of bureau (St Andrew's healthcare staff) and agency staff to support people.

Good

Psychiatric intensive care units and health-based places of safety

Are psychiatric intensive care units safe?

Good

Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this. Staff received training in the management of violence and aggression. We found that restraint was used safely and only as a last resort.

We found staff reported any incidents/accidents and there was a system in place for reviewing and learning from them to prevent a reoccurrence.

Risk assessments and management plans were available for people and the environment to keep them and others safe.

Systems were in place to ensure adequate staffing and skill mix. For example, we found that the provider used a recognised tool for identifying people's dependency needs and the level of staffing required. Nursing staff rotas were planned four to six weeks ahead. Some concerns were identified across both locations about the high use of bureau and agency staff on each unit.

We found that the wards were clean and staff practised safe infection control procedures to minimise the risk of cross-infection.

Safe and clean ward environment

Environmental risk assessments such as a ligature audit were completed with actions identified as relevant to manage risks. There was a separate seclusion and intensive care unit which allowed clear observation with two-way communication, toilet facilities and a clock. A nursing station had clear visibility of the dining area and partial sight of the lounge area. Each bedroom door had observation panels. There were locked doors and corridors and people were encouraged to spend time out of their room during the day. Some staff reported challenges with the layout of the PICU stating it was not purpose built. However this was not supported by our observations.

The ward was clean, had good furnishings and was well-maintained. For example, there was fixed dining furniture; also specific furniture available in the event of staff needing to use sitting restraint. Strong clothing was available for people where relevant to reduce the risks of people self-harming with clothing. Ward cleaning schedules were in place with audits undertaken by senior staff. One person told us, "it's like a five star hotel."

A fully equipped clinic room with resuscitation equipment and emergency drugs was available and checked regularly. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that people had access to medicines when they needed them. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature as recommended by the manufacturer.

Staff and visitors were given personal alarms when entering the unit and systems were in place to regularly check them. There was a policy for observations and staff recorded checks of people. Some of those records seen were not clear and staff told us this was when people were observed in the communal areas and they would take action to detail this further.

Security policies and procedures were available. Trained dogs could be brought to the ward to search for drugs if required. There was a list of restricted items on the unit to reduce the potential risks of self-harm or harm to others. A procedure was in place for randomly searching staff and people who used the service.

Safe staffing

Dr Hurst's mental health, learning disabilities tool for identifying staffing levels was being piloted in some areas of the charity. This was not being used in the Essex location. The tool is used to identify people's dependency needs and the level of staffing required. This Association of United Kingdom University Hospitals (AUKUH) acuity and dependency tool has been developed to help hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tool, when allied to nurse sensitive indicators (NSIs), will also offer services a reliable method against which to deliver evidence-based workforce plans to support existing services or the development of new services. Dr Hurst's mental health / learning disabilities tool for identifying staffing levels was used to identify people's dependency needs and the level of staffing required.

Nursing staff rotas were planned four weeks ahead. A doctor was on call 24 hours a day and on site night staff accommodation was available.

Daily hospital wide planning meetings reviewed staffing levels and needs and a red amber green (RAG) system was used to identify risk areas. Additional staff were requested using a centralised electronic system 'Trinity'. Most staff reported flexibility of staffing numbers to be able to respond to the need for enhanced observations. We reviewed the current duty rotas for this ward. We found that there were nine staff on duty caring for ten people, whereas staff told us there were usually six staff on shift (two nurses and four healthcare assistants).

A staff member told us that there were challenges as they were often observing people without a break. This was bought to the attention of the unit manager.

Staff who had worked on the ward before, and who had been trained in the use of restraint were usually requested to ensure consistency of care. An induction checklist, 'Do you know your ward' was available to orientate new staff and we saw examples of these having been completed. We found that agency staff on the unit had only been required since December 2013. This was as a result of the PICU opening a few months earlier.

Assessing and managing risk to patients

The provider had a system for ensuring that people had risk assessments following admission and regular updates such as the evidence based tool developed by the Institute of Psychiatry, 'threshold assessment grid' risk screening tool, (TAG). A recently reviewed risk monitoring system was also in place which detailed, for example, the access people could have to items in their room and escorted leave off the ward. People's risk level was reviewed and detailed in daily notes. However some did not detail the rationale for decisions made.

There was a clear cut demarcation between seclusion and segregation. Reviews took place and we saw that the level of observation changed as people's risks reduced. A monthly unit multi-disciplinary meeting took place to review enhanced support for people. This gave an additional opportunity to review people's care and long term seclusion/segregation. A system was in place to arrange for doctors across wards to give a second opinion/ independent review on the management of individual cases.

People had specific care plans for prevention and management of aggression and violence (PMVA) segregation and advanced statements could be made by people if they wished. PMVA and seclusion record audits took place with actions identified as required. The St Andrew's Healthcare Essex PMVA audit highlighted that improvements were needed for recording such observation levels, support required, patient debriefing and management of lowering mood.

We saw that staff undertook physical observations when people had been given rapid tranquilisation. However there was not one system for identifying where this information was kept as both paper and electronic records were held. Staff reported challenges with agency staff accessing RiO. We saw that paper held information about people was not always as up to date as RiO records.

A staff PMVA trainer was on site and gave input into plans. Staff across wards and department told us seclusion and restraint was "a last resort" and the first choice was to use de-escalation techniques. Prone restraint was taught as part of PMVA training and records were kept when this was used with people. Managers confirmed that this practice was currently under review. Staff told us that people would be moved out of a prone position as soon as possible. This was supported by those seclusion and restraint records seen

Staff received personal security in a secure environment (PSSE) training on induction and PMVA training was given after three months. There were alarm systems to summon assistance and security staff had PMVA training and also undertook restraint in addition to other disciplines.

Staff received mandatory training on safeguarding vulnerable adults and children. We found that 95% of staff at St Andrew's Healthcare Essex had undertaken level 2 training. Level 3 training was planned for the next two months and a session took place the week of our visit. The safeguarding reporting procedures had been reviewed since our visit in December 2013. There was a safeguarding log and systems to review this at management and ward/ team level. For example, 'safeguarding' was a standard agenda item at the monthly business continuity meeting with staff and people using the service.

Care plans were in place when people were identified as being vulnerable or at risk to others. Monthly multi-agency

safeguarding meetings took place with the local authority and the police. Multi-agency public protection arrangements (MAPPA) to review safeguarding incidents and investigations were in place.

Staff were given further information about reporting safeguarding concerns at staff forums in 2014 and they had received a leaflet, "safeguarding patients: recognising and responding to abuse - a guide for staff". Most staff had a good understanding about safeguarding and knew how to report any issues.

We reviewed medicines administration records (MAR) on this unit. Appropriate arrangements were in place for recording the administration of medicines. Records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. This meant people were receiving their medicines as prescribed. If people were allergic to any medicines this was recorded on their medication administration record chart. Medicines interventions by a pharmacist were recorded on the MAR charts to help guide staff in the safe administration of medicines.

A pharmacist visited the ward weekly. Pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. Each patient had a medication profile on the pharmacy information technology system where each medicine had to be clinically approved by a pharmacist before it could be dispensed.

Reporting incidents and learning when things go wrong

Most staff were aware of the systems to report and record incidents in the electronic patient' RiO' and 'Datix' system record. There were systems for reviewing these to consider actions to minimise any risks at local and provider level such as the hospital's daily handover meeting; patient safety and experience group and quality and compliance groups.

A system for disseminating any learning points/actions identified had been developed where staff received 'patient safety alerts' by poster and email. This was now adopted across the organisation. A system was in place for reviewing and monitoring when staff had read them.

Alerts were further discussed at team/ward meetings to embed learning. Minutes we saw did not always detail the discussion around this. Most staff we spoke with could refer to this and gave examples of learning and changes made**.** A recent alert from August 2014 highlighted the process to be followed when controlled drugs were delivered to wards. Windows were being replaced across the unit following actions identified after an incident where a person broke one and gained access to the garden. Staff reported that debriefs took place after incidents. A trauma counsellor was accessible to staff where required.

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Are psychiatric intensive care units effective?

(for example, treatment is effective)

Good

Outcomes for people were also assessed through use of the Health of the Nation Outcome Scale (HoNOS) secure assessment tool. A range of therapeutic interventions in line with National Institute for Health and Clinical Excellence (NICE) guidance took place.

We saw evidence in people's care and treatment records of how the service had reviewed and amended treatments in order to meet their changing assessed needs.

We found effective multi-disciplinary working (MDT) within the service to meet peoples' needs. Both units had clear procedures in place regarding their use and implementation of the Mental Health Act and the Mental Health Act code of practice. Advocates were available to people throughout these units and most people we spoke with told us they were aware of their rights.

Staff confirmed that they had received mandatory training and this was confirmed by those records seen. We found that staff had access to regular supervision and staff had received annual appraisals. We saw examples of additional training being provided for unit based staff.

We received mixed feedback about the availability of activities at both locations. However systems were in place to monitor this. We found that some staff had difficulty accessing the electronic care and treatment records in use.

Good

Psychiatric intensive care units and health-based places of safety

Assessment of needs and planning of care

We reviewed five people's care plans and saw the provider has a standard for assessments taking place within 48 hours of admission. Some staff gave an example of not being provided with a full history about a person before their admission due to information not being shared by previous placement staff. They told us that sometimes this information was likely to have affected their decision to admit the person.

Template "care plan libraries" were available for staff to use. Care plan headings and daily notes reflected the use of recovery tools such as 'my shared pathway' (MSP).

People had a physical health examination and an annual health check with additional assessment and care plans as required such as for smoking cessation. Information was available to staff about recognising the right of people to smoke and the need to monitor their health. Nicotine replacement therapy was prescribed when people were in seclusion/segregation could not access tobacco.

A person returned from an acute hospital following physical healthcare treatment had a care plan in place to safely manage them on return. Systems were in place to communicate key information about people to acute hospital staff.

The provider had an assessment log to keep track of when assessments relating to people's care and treatment have been completed or were out of date. There were systems for this to be checked weekly by the ward manager and by the multi-disciplinary team.

Best practice in care and treatment

Care plans were available if the person was prescribed clozapine or high dose anti-psychotic medication. Additionally doctors were now using the Glasgow antipsychotic side-effect scale (GASS) assessment to determine if people were suffering from excessive side effects from their antipsychotic medication to help inform care plans. Outcomes for people were also assessed through use of the Health of the Nation Outcome Scales (HoNOS) secure assessment tool.

A range of therapeutic interventions in line with National Institute for Health and Care Excellence (NICE) such as mindfulness and cognitive behavioural therapy took place. We saw evidence of effective use of cognitive behavioural therapy with individuals. This had led to a decrease in incidents including self-harm for individuals.

Additionally groups included using nationally recognised approaches such as STEPPS (systems training for emotional predictability and problem solving). NICE guidelines were referenced for staff to follow for example in policies on chronic disease monitoring and in acute and chronic wound care (for people who self-harm).

The provider had timetables to offer people a weekly minimum of 25 hours therapeutic activity and for tracking attendance. During our visit we saw activities such as karaoke taking place with people. Activities were provided for people who required long term seclusion/segregation.

We received mixed feedback from people about the suitability of activities. A person told us they were "childish"; another told us they were "happy" with them. Nursing staff undertook weekend activities' and there was an identified activity coordinator. Some staff reported challenges with providing varied activities due to staffing levels and the need for enhanced observations for some people.

We saw the provider had responded to the 2010 National Patient Safety Agency (NPSA) rapid response alert 'reducing harm from omitted and delayed doses' by doing regular audits to check how many doses were omitted or delayed. We saw missed doses were recorded on the provider IT system (Datix) so the provider could check if patients were receiving their medicines as prescribed.

The provider had a central audit team with audits undertaken at provider and location level, for example monthly care plan audits. Each month pharmacy staff completed a comprehensive audit on every ward to check medicines were being managed safely. We saw if any issues were identified an action plan was put in place, with dates for actions to be completed. Recently medicines 'champions' had been nominated on each ward.

Skilled staff to deliver care

Each ward had an identified multi-disciplinary team including doctors (including a consultant psychiatrist), nursing, occupational therapy (OT), psychology and social work staff. Additionally there was access to specialist staff such as a dietician, physical fitness instructor and chaplain.

Good

Psychiatric intensive care units and health-based places of safety

Staff confirmed that they had received mandatory training and this was confirmed by those records seen. We found that staff had access to regular supervision and staff had received annual appraisals.

Additional training being provided for unit based staff and this included emergency and relational security training, carrying out enhanced observations and search training. Additionally training took place for reducing the risk of self-harm and suicide. For example, 'knowledge and understanding framework (KUF)' training for working with people who had a personality disorder.

Multi-disciplinary and inter-agency working

The ward had shift handovers between each shift. Staff worked long days and reported being given handovers if they were off duty by the nurse in charge if off duty for over three days. New nursing handover sheets related to the relational security explorer, from the 'see, think, act' Department of Health Handbook were seen and had been completed appropriately.

A daily morning planning meeting was attended by staff across wards/department to report key issues for the ward/unit such as staffing, incidents, leave, safeguarding and admissions.

Staff reported regular contact with the multi-disciplinary team (MDT); with regular and effective meetings. For example, MDT staff attendance at the morning community meeting and debrief afterwards.

The provider had systems in place for MDTs to liaise with community team and the care coordinator from the person originating area were invited to CPA review meetings to give feedback on the person's care and treatment.

Adherence to the MHA and the MHA Code of Practice

91% of hospital based staff had undertaken MHA training. The ward had clear procedures in place regarding their use and implementation of the Mental Health Act and the Mental Health Act code of practice. Advocates were available to people on the ward and most people we spoke with told us they were aware of their rights.

We found that procedures were in place for planned and emergency admissions and the records showed us that people had been informed of their rights of appeal against their detention. Staff produced statutory reports where people had appealed against their detention to first tier tribunals and hospital managers' hearings.

We saw there were checks when patients were detained under the Act to ensure that the correct legal documentation for treatment for mental disorder were completed and available. We found no discrepancies between the medicines prescribed and those on the authorised consent forms and there were weekly and monthly checks to ensure these forms were correct.

We identified an issue with detention paperwork for a person and staff advised us of the action they would take to clarify the matter.

Good practice in applying the MCA

91% of hospital based staff had undertaken Mental Capacity Act 2005 training including training relating to deprivation of liberty safeguards (DoLS).

We saw that the provider had systems in place to assess and record people's mental capacity to make decisions and develop care plans for any needs. Most staff demonstrated awareness of the Act.

Are psychiatric intensive care units caring?

Good

Most people told us staff were approachable and that they gave them appropriate care and support.

The provider had systems to encourage people to be involved in their assessment, care planning and reviews through use of recovery tools such as 'my shared pathway'. People had the opportunity to attend a hospital based 'service user forum'.

We found that people who used the service were treated with dignity and respect.

Kindness, dignity, respect and support

We observed that staff treated people with dignity and respect. Most people gave positive feedback about the staff group and examples of the kindness of some individual staff. For example one person told us that they were

Good

Psychiatric intensive care units and health-based places of safety

"getting better" on the unit. However, some people expressed their concerns about the attitude of individual staff members. These concerns were bought to the attention of the unit manager.

People received an information pack on admission. A range of information was displayed for people such as health promotion. People had identified keyworkers and opportunities to meet with them, although some people were not clear who their key worker was. People had access to a telephone subject to risk assessment.

The involvement of people in the care they receive

Daily community meetings took place and staff supported people to give their views but also acted as mediator to deal with issues that people raised. People had the opportunity to attend a hospital based 'service user forum'.

We saw evidence of people's involvement in care plans and their views recorded. However this was not evident for those seclusion care plans seen. The lead OT told us that people were given a copy of the range of activities available and then chose what they wanted to attend. This was then negotiated with the MDT and agreement gained for their activities timetable.

We saw clear documentation recording when people had been advised of their legal rights. We saw people could request and had access to independent support to help communicate their needs such as solicitors and staff responded to this. We saw information publicising the independent mental health advocate (IMHA) service on the unit. This service was based on site with identified ward sessions.

Staff told us that they liaised with people's carers and relatives as agreed with by the person. Staff reported having regular contact with some carers. For example, there were systems to ask people whom they wanted invited to meetings. Carer's needs assessments could be requested from the person's local mental health team.

Are psychiatric intensive care units responsive to people's needs?

(for example, to feedback?)

Good

People were referred to the service from within the organisation and externally. Discussions were held on each unit with the clinical team regarding the appropriateness of referral.

The service had access to interpreters when necessary. We saw that information was available about activities and services which were available within each hospital.

Some people told us that the food provided was good. Food was prepared on site and people could choose from a menu.

There was an effective complaints management system in place. There was evidence of site developments to respond to people's assessed needs. However there were not consistent systems for staff to respond to and meet people's diverse cultural and language needs.

Access, discharge, and bed management

During our visit nine women were using the service. There were systems for staff to assess people prior to admission. The hospital director told us that staff tried to assess people within 48-72 hours of referral.

The ward manager said the admission was ward led. Some staff told us that they admitted challenging people when other providers did not want them and that the staff focus was taken up with managing the acutely ill rather than those who were recovering.

Staff told us the average length of stay varied and averaged between six to eight weeks. This was supported by those records reviewed. A weekly unit bed management meeting telephone conference took place with the central St Andrew's Healthcare site to review referrals, admissions transfer and discharges.

Most people were placed from outside the local area from various areas of the United Kingdom. Sometimes a person might be admitted as there was not an identified placement available in their home area and it may be a short time before a bed became available and they were

moved back or they might be transferred to a hospital with higher security. Alternatively, people could move to another ward within the hospital when their risks reduced or return to a ward in their home area.

Some staff reported that some people's transfer/discharge could be delayed when there was not an identified placement in their local area or a specialist placement to move to or when there were funding issues which was beyond the provider's control as this was the responsibly of the person's home commissioning team.

The ward environment optimises recovery, comfort and dignity

People did not have community leave due to acute nature of the mental health and the risks they posed. People had access to fresh air in the garden subject to risk assessment. Agreed visits took place with staff support as required either in the ward meeting room or dining area which staff said was not ideal as there was one meeting room. We noted that the use of vacant bedrooms was being reviewed to consider if they could have additional meeting rooms/ therapy space.

A' three item rule' of buying food from the on-site shop/café was made. This was in response to staff concern about people gaining weight and needing to encourage healthy eating.

Ward policies and procedures minimise restrictions

There were periods when access to bedrooms would be limited by locking the door which allowed access to the bedroom areas. This meant that people were restricted in their access to their bedrooms. Some staff told us that this happened to encourage people to participate in daytime activities. There were specific times when people had access to hot drinks.

Meeting the needs of all people who use the service

People had an identified social worker employed by the provider and social work 'drop in' sessions took place for people to meet with them to raise issues such as plans for the future, their finances and family issues. Systems were in place for people who could not easily access their bank to have payment made into an account at the charity so as to give people easier access to their monies during their admission.

Some people told us that the food provided was good. Food was prepared on site and people could choose from a menu. The provider had systems to assess and monitor the quality of the catering service and gain feedback. Access to the ward kitchen was restricted due the risks people could pose to themselves or others. There were identified meal/ refreshment times for people.

There were systems in place to record people's diverse need such as religion and ethnicity. There was a diversity group for staff and the lead social worker told us they were trying to start one for people using the service. However it was unclear how staff were responding to people's diverse requests. One person requested access to an interpreter and wanted information provided to them in their first language which was not English. Another person told us they had previous access to an interpreter but they did not understand them.

Some staff told us the social worker could contact the central Northampton site for services and there was an external agency that provided interpreting services. MHA staff told us that they had access to written information about people's legal rights right for people where English was not their first language. We saw a chaplaincy service was provided on site. Two people told us they had made requests for support with their religious needs and were still waiting for a response, one to meet with an Imam and another to see a Catholic priest.

Listening to and learning from concerns and complaints

Information was displayed on the ward for people to report any 'concerns, complaints, compliments' and there were systems for them to be investigated and complainants to be given a response. There were additional systems for people to raise issues at community meetings. We observed that people felt able to raise with staff a problem about their telephone cards not working and that staff responded appropriately. Information about complaints were reviewed at staff meetings and feedback given on any that were upheld and to minimise any reoccurrence.

There were electronic systems for staff to report any maintenance issues for repair. Maintenance staff were based on site and could respond to emergency repairs. During our visit we noted that the ward office was very warm. Staff expressed frustration that they had reported

the matter several times, maintenance work had been undertaken but the problem was not resolved. This was bought to the attention of senior staff during the inspection.

Are psychiatric intensive care units well-led?

Good

We found that the provider provided information to staff and people about their service in different and effective ways. Most staff were aware of the provider's core values.

The provider had a governance framework in place at each unit with links for feedback to/from the central site at Northampton. For example we noted that 'out of hours' visits by senior staff and unannounced visits from directors took place with reports on the quality and experience of care provided.

Most staff reported support from their manager. They told us they undertook training and had supervision, team meetings and appraisals to ensure they were competent and confident in their role. Most staff reported that managers were approachable and they were effective leaders.

We noted that the ward manager for Frinton ward was new in post and worked across two wards.

People and staff were encouraged to give feedback on the quality of the service in various ways such as meetings and surveys.

We noted that some action plans detailing the provider's response to direct people's feedback were not available. This meant that it was unclear whether or not they had received a response.

Vision and values

Information about the provider's vision and values were displayed across wards. Staff were kept informed of developments via email and the intranet. Staff reported contact with senior managers in the organisation and these managers have visited the ward. Quarterly staff briefing meetings were held with the hospital director.

Good governance

We found that there were governance systems and meetings at the hospital and within the organisation to review and report for example on incidents, audits and complaints and develop plans for actions needed. Lead staff reported links with managers/peers at other St Andrew's healthcare locations with opportunities to visit have telephone/video conference.

There were staff resources to deliver training on site and via 'e learning'. Training leads were based on site and had links with managers and peers across the organisation. The ward manager reported good links with training team. A staff member told us the provider had funded their cognitive behavioural therapy training at university and they had mentorship on site from the lead psychologist. They were currently providing this service to other wards within the hospital.

Staff recieved appraisals and there were systems in place for staff to receive professional supervision. For example, nursing staff could receive'30:30' managerial supervision (30 minutes every 30 days).

In July 2014, 100% of clinical supervision was achieved across the ward. However the ward manger told this was not currently 100% due to staff sickness and annual leave. Staff referred to 'reflective practice' sessions taking place where staff had the opportunity to discuss with their peers any issue or concerns about people they were working with.

There were opportunities for staff to undertake specialist training as relevant for their work such as emergency and relational security training, detailing their role as escort, carrying out observations and search training. Training took place for reducing the risk of self-harm and suicide. For example, 'knowledge and understanding framework (KUF) training' for working with people who had a personality disorder was delivered with a person who was using this service.

Some staff across these two units told us that they considered that there was too much paperwork/ bureaucracy which they felt was being cascaded from the central site without understanding how it impacted on the staff and their ability to work with people.

Leadership, morale and staff engagement

Good

Psychiatric intensive care units and health-based places of safety

Staff comments included, “it’s a nice place to work and rewarding”. However another person told us that, “I feel burnt out”. During our visit we noted that when the ward was busy; staff were not always available to answer the telephone.

The ward manager told us they were new in post and worked across the PICU and another ward. We received some positive feedback from staff about their support and leadership although some staff told us the manager was rarely on the ward. Some staff told us there had not been a unit specific manager for some time. We found that deputy ward managers were in post to provide support to the unit manager.

We heard mixed feedback from staff about the level of support given by the provider. Some staff told us that morale was “low”, whereas other reported “positive” support and good team working.

Some staff told us that there had been significant staff sickness however this was not confirmed by other staff. Information from the provider indicated that this hospital had the highest staff sickness statistics in the organisation at 7%. We saw the provider had a human resources department and referred staff to occupational health services where applicable. Staff could have a graduated return to work. The hospital director told us the provider had paid for staff to receive therapy.

The hospital director had identified there were challenges with recruitment and retention of staff for the unit and the provider had plans in place for this. They now offered a recruitment payment to new nursing staff as an employment incentive. The provider conducted exit interviews so as to track reasons why staff may be leaving.

Systems were in place to gain people’s views such as in the recent ward ‘patient survey’ and ’catering survey’. However, the provider actions plans in response to these surveys were not available for inspection. This was bought to the attention of senior staff within the hospital.

We were informed of, ‘ask the hospital director’ sessions available for staff to meet them and give feedback on issues. There were systems for staff to ‘whistle blow ‘or to anonymously raise issues via the provider’s ‘Safe call’ system.

Staff told us they could give feedback to senior staff via email. However they told us they did not always get a response or felt there were not always opportunities for further discussions with them.

Commitment to quality improvement and innovation

The hospital director told us they received weekly reports on the quality of the services provided. Key performance indicators and other systems were available at ward meetings for staff to gauge their performance in comparison to other wards in the hospital. For example for safeguarding, incidents, complaints and absence without leave (AWOL). Information was analysed and also aligned in the five domains (safe, effective, caring, responsive and well led).

Out of hours visits by senior staff and unannounced visits from directors with reports on the quality and experience were fed back to the ward. We found that senior staff from wards and department attended hospital based ‘quality and compliance’ groups and action plans arising from these meetings were displayed in the unit.

We reviewed the latest staff survey results for the hospital and dated February 2014. This demonstrated to us an increased overall staff satisfaction in most areas. We noted that staff reported overall no improvement with communication with senior management.

Good

Long stay/forensic/secure services

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

Information about the service

St Andrews Healthcare Essex is a low secure hospital located in North Benfleet, Essex. The hospital is registered to accommodate 92 adults who have mental illness and can be detained under the Mental Health Act 1983. Accommodation is on the ground and first floors. There is a separate step down unit, which was completed in April 2009.

On the day of our inspection there were 58 people receiving assessment and treatment in this service; 57 of these people were detained under the 1983 Mental Health Act. We found that that the informal person had agreed to stay in the step down service whilst an appropriate future placement could be found for them.

The provider had three outstanding compliance actions from previous Care Quality Commission inspections dated December 2013 and May 2014 for this location. The Commission had received a written action plan from the provider demonstrating how they would achieve compliance with these relevant regulations. This had been updated regularly by the provider. As a result of this inspection; we found that the provider was now compliant with these regulations.

Summary of findings

Overall we found that improvements were required as the services provided were not always safe. Actions from ligature audits were not followed through on one ward and care and treatment records were incomplete in respect of one person's physical healthcare needs. This meant that people may be at risk of unsafe care and treatment.

There were systems in place to ensure an effective service. Surveys and audits measured the quality and effectiveness of systems.

The services provided were caring. This was confirmed by our observations of the care and treatment being provided and subsequent discussions with staff.

The services provided were responsive. Evidence was seen that demonstrated to us that the provider encouraged feedback from people and staff to influence the running of the service.

The services provided were well led. Most staff told us that they felt supported. Staff across all of the wards inspected told us that there were difficulties with the recruitment and retention of staff. We found that there was widespread use of bureau (St Andrews healthcare staff) and agency staff on the wards inspected.

Good

Long stay/forensic/secure services

Are long stay/forensic/secure services safe?

Overall we found that improvements were required as the services provided were not always safe. Actions from ligature audits were not followed through on one ward and care and treatment records were incomplete in respect of one person's physical healthcare needs. This meant that people may be at risk of unsafe care and treatment.

Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this. Staff received training in the management of violence and aggression. We found that restraint was used safely and only as a last resort.

We found staff reported any incidents/accidents and there was a system in place for reviewing and learning from them to prevent a reoccurrence.

Risk assessments and management plans were available for people and the environment to keep them and others safe.

Systems were in place to ensure adequate staffing and skill mix. For example, we found that the provider used a recognised tool for identifying people's dependency needs and the level of staffing required. Nursing staff rotas were planned four weeks ahead. However some concerns were identified across this location about the high use of bureau and agency staff on the wards.

We found that the wards were clean and staff practised safe infection control procedures to minimise the risk of cross-infection.

Safe and clean ward environment

On Audley ward we found that a ligature point risk assessment had been completed with actions identified to manage the risks. However, when we spoke to staff about the identified risk due to the door handles within communal areas, and asked to see records for the hourly checks that were identified as an action, we were told that this was not available. We bought our concerns to the attention of senior staff within the unit and the hospital.

The seclusion suite on Audley ward had two-way communication facilities, a clock and toilet facilities. However, we observed a person having to be moved from Audley ward to Hadleigh ward to be secluded. When we spoke to staff they told us that in the bathroom of the seclusion suite on Audley ward they could not maintain clear observations due to a blind spot. We were told that the provider was taking action to address this issue as part of the refurbishment programme taking place during our inspection.

We were told that emergency resuscitation drills did not take place as part of ongoing staff training and noted that Hadleigh ward did not have resuscitation equipment despite having a seclusion and intensive care area. This equipment was available in the adjacent ward.

There was a pharmacy top-up service for ward stock. Other medicines were ordered on an individual basis. This meant that people had access to medicines when they needed them. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature as recommended by the manufacturer.

We saw controlled drugs were stored and managed appropriately. However, on Maldon ward one controlled drug was not being stored in line with the provider's policy as there was no controlled drug cupboard on this unit. This was bought to the attention of senior staff within the hospital.

Overall, the wards were clean, had good furnishings and were well-maintained. Ward cleaning schedules were in place with audits undertaken by senior staff. Staff told us there were systems for the "lock down" of the ward should an infection arise. Household cleaning products had been risk assessed as part of the control of substances hazardous to health (COSHH) and there were systems to ensure they were securely stored. Emergency equipment was available and checked regularly.

We noted an unpleasant smell across the site. We were informed that this was due to problems with the site's drainage system. One person showed us the ensuite shower in their bedroom and told us that water had been flowing back up the plug hole for some time and that this resulted in a foul smell. Senior management were aware of the problem and we noted that the maintenance team were trying to resolve the issue.

We noted some areas within the ward areas were excessively warm. We were informed that the provider was investigating the cause of this and received assurances that plans were in hand to address this issue.

Good

Long stay/forensic/secure services

Safe staffing

Dr Hurst's mental health, learning disabilities tool for identifying staffing levels was being piloted in some areas of the charity. This was not being used in the Essex location. The tool is used to identify people's dependency needs and the level of staffing required. This Association of United Kingdom University Hospitals (AUKUH) acuity and dependency tool has been developed to help hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tool, when allied to nurse sensitive indicators (NSIs), will also offer services a reliable method against which to deliver evidence-based workforce plans to support existing services or the development of new services. Dr Hurst's mental health / learning disabilities tool for identifying staffing levels was used to identify people's dependency needs and the level of staffing required.

Nursing staff rotas were planned four weeks ahead. A doctor was on call 24 hours a day.

Daily hospital wide planning meetings reviewed staffing levels and needs and a red amber green (RAG) system was used to identify risk areas. Additional staff were requested using a centralised electronic system 'Trinity'. Most staff reported flexibility of staffing numbers to be able to respond to the need for enhanced observations.

On Easton Lodge, at times there was one member of staff due to being a small ward and people being assessed as more independent. Staff told us they could call for assistance from other staff on the site and site security if required, in an emergency.

On Danbury and Audley ward some staff said that despite staff rotas booking sufficient staff, they might be redeployed elsewhere in the hospital to support colleagues. This sometimes led to people having their Section 17 leave being cancelled, which two people confirmed with us.

Staff reported a high use of bureau (St Andrew's Healthcare staff) and agency staff. We saw some examples of difficulties in covering weekend and evening shifts. This could affect staff being able to take their breaks and provide leisure activities for people who used the service.

Some staff gave us examples of bureau and agency staff being used on wards that they were not familiar with. On some occasions, emergency response team staff said that they could not leave the ward to respond to emergency situations elsewhere in the service as they had to ensure a minimum of three staff stayed on the ward. We noted that in these situations additional support was given by security staff within the hospital.

Some people told us access to healthcare was poor as they had to wait to see a doctor but also said a GP visited weekly. Senior staff told us that 80% of people using the service smoked cigarettes. Smoking cessation support was available with nicotine supplements for those who wanted to stop. People's physical health needs were being appropriately monitored with regular checks completed for weight and blood pressure.

Assessing and managing risk to patients

We reviewed care records and we saw that most people's needs and risks were assessed and documented. The risk assessments detailed the actions that were required to minimise the risk to the individual, trigger behaviours and coping strategies. For example, staff assessed and supervised on wards people's access to sharp objects and other items that might present a risk to them or others. Most people who used the service told us that they felt safe. Gaps were noted in two records seen regarding the individual risk reviews carried out on each person. This was bought to the attention of unit based staff.

On Maldon ward we found that one person who had a serious enduring physical health need did not have a care plan or risk assessment in place to alert front line staff or provide guidance on how to help support and care for the person. When we spoke with staff they were not aware of any procedures that should be being followed or documentation that should be completed as a result of this physical health condition. The records seen did not demonstrate to us that this person was having their physical health needs met effectively by the service.

Staff had undertaken training in and where appropriate had used reinforce appropriate implode disruptive (RAID) interventions when working with people who may challenge. We noted that staff used 'think back forms' with people as part of behaviour analysis after incidents and these were used to promote reflection on incidents and in clinical team decision making about changing risk status levels.

Good

Long stay/forensic/secure services

Staff received personal security in a secure environment (PSSE) training on induction and PMVA training was given after three months. There were alarm systems to summon assistance and security staff had PMVA training and also undertook restraint in addition to other disciplines.

Staff received mandatory training on safeguarding vulnerable adults and children. We found that 95% of staff at St Andrew's Healthcare Essex had undertaken level 2 training. Level 3 training was planned for the next two months and a session took place the week of our visit. Safeguarding reporting procedures had been reviewed since our visit in December 2013. There was a safeguarding log and systems to review this at management and ward/ team level. For example, 'safeguarding' was a standard agenda item at the monthly business continuity meeting with staff and people using the service.

Staff were given further information about safeguarding reporting procedures at staff forums in 2014 and they had received a leaflet, "safeguarding patients: recognising and responding to abuse - a guide for staff". Most staff we spoke with had a good understanding about safeguarding and knew how to report any issues.

Reporting incidents and learning when things go wrong

Most staff were aware of the systems to report and record incidents in the electronic patient' RiO' and 'Datix' system record. There were systems for reviewing these to consider actions to minimise any risks at local and provider level such as the hospital's daily handover meeting, patient safety and experience group and the quality and compliance groups.

A system for disseminating any learning points/actions identified had been developed where staff received 'patient safety alerts' by poster and email. This was now adopted across the organisation. A system was in place for reviewing and monitoring when staff had read them.

Alerts were further discussed at team/ward meetings to embed learning. Minutes we saw did not always detail the discussion around this. Most staff we spoke with could refer to this and gave examples of learning and changes made**.** For example, the provider changed the office doors to ensure that people could not reach in and grab items out of offices.

Staff reported that debriefs took place after incidents. A trauma counsellor was accessible to staff where required.

Are long stay/forensic/secure services effective?

(for example, treatment is effective)

Outcomes for people were also assessed through use of the Health of the Nation Outcome Scale (HoNOS) secure assessment tool. A range of therapeutic interventions in line with National Institute of health and care excellence (NICE) took place.

We found effective multi-disciplinary working (MDT) within the service to meet people's needs. The location had clear procedures in place regarding their use and implementation of the Mental Health Act and the Mental Health Act code of practice. Advocates were available to people throughout the hospital and most people we spoke with told us they were aware of their rights.

Staff confirmed that they had received mandatory training and this was confirmed by those records seen. We found that staff had access to regular supervision and staff had received annual appraisals. We saw examples of additional training being provided for unit based staff

We received mixed feedback about the availability of activities. However we saw systems were in place to monitor this. We found that some staff had difficulty in accessing the electronic care and treatment records used throughout the hospital.

Assessment of needs and planning of care

Care plan headings and daily notes reflected the use of recovery tools such as 'my shared pathway' (MSP). Care records had clear plans and guidance for staff on how to support people who used the service to achieve their goals, whilst promoting independence. We saw evidence of people's diverse needs being met within care plans. For example information about people's cultural or spiritual needs. We saw that most care plans were developed with people's involvement. Some people told us that they kept a copy of their care plan in their bedrooms.

People had a physical health examination and an annual health check with additional assessment as required such as for smoking cessation. Information was available to staff about recognising the right of people to smoke and the

need to monitor their health. Nicotine replacement therapy was prescribed when people were in seclusion/segregation and could not access tobacco. Systems were in place to communicate key information about people to acute hospital staff when required.

The provider had an assessment log to keep track of when assessments relating to people's care and treatment have been completed or were out of date. There were systems for this to be checked weekly by the ward manager and multi-disciplinary team.

Best practice in care and treatment

Staff offered therapy as recommended by national guidance, such as cognitive behavioural therapy (CBT). The head of programmes told us that six people were undertaking CBT, which was used where people had been in hospital a long time. Some staff were being trained in CBT. Staff gave an example of working with a person to overcome their phobia. Other therapies offered included 'stop and think' problem solving groups, mindfulness and advanced relapse prevention. A member of psychology staff was attached to each ward and 'drop in' sessions also took place on wards.

We saw good examples of effective outcomes achieved as a result of these therapies with individuals. For example, a reduction in incidents and self-injurious behaviours.

Outcomes for people were also assessed through use of nationally recognised assessment tools such as health of the nation outcome scales (HoNOS) secure, HCR20 -Historical Clinical Risk Management.

Staff encouraged people to use the recovery star self-assessment tool and the my shared pathway (MSP) booklets. MSP is part of the national secure services QIPP programme. It is developing a recovery approach to identifying and achieving outcomes and aims to streamline the present pathway for service users in secure services. People identified their needs with staff and outcomes they want to achieve with timelines. This influenced their care plans.

OT staff reported using assessment tools to measure people's progress such as the occupational self-assessment (OSA) and the model of human occupation screening tool (MOHOST).

There were systems to provide a minimum of 25 hours of therapeutic activity in the week. Activities such as 'breakfast club', sport activities and social skills were offered. Information was available to ward staff about the number of therapeutic hours provided to people. For example on Danbury Ward, from 04 to 10 August 2014, 20% of activities were recorded by staff as attended; 20% not and 60% were waiting to be 'outcomed' as staff had not yet recorded people's attendance. This lack of effective recording was bought to the attention of senior staff during the inspection.

During a morning visit, we observed several people asleep in chairs. We saw that some activities were taking place off the ward. Senior staff told us that they would take action to ensure more encouragement was given to people to attend activities.

On Easton Lodge, staff reported undertaking individualised activities with people such as money management.

Skilled staff to deliver care

Each ward had an identified multi-disciplinary team including doctors (Including consultant psychiatrists), nursing, occupational therapy (OT), and psychology and social work staff. Additionally there was access to specialist staff such as a dietician, physical fitness instructor and chaplain.

Staff confirmed that they had received mandatory training and this was confirmed by those records seen. We found that staff had access to regular supervision and had received annual appraisals.

The records seen showed us that the provider was recruiting staff on an on going basis and that induction training was provided each month for new staff. However, we noted difficulties with staff retention once people had completed their induction programme. This was confirmed by those staff retention figures reviewed.

Multi-disciplinary and inter-agency working

Each ward had shift handovers. Staff reported that if they had been off duty from the ward for more than three consecutive days the nominated safety nurse gave them a full handover and a health and safety checklist was completed to ensure that staff were aware of people's current care and risk behaviours.

New nursing handover sheets related to the relational security explorer, from the 'see, think, act' Department of Health handbook. Some staff reported it was not an

improvement to the previous one and we saw it was difficult to read some handwriting. A daily planning meeting was attended by staff across all wards/department to report key issues for the ward/unit such as staffing, incidents, leave, safeguarding and admissions.

We spoke with agency staff who told us that they did not have access to the RIO system. They solely relied on the paper handover sheets. This meant that they did not have full access to people's medical notes and were not always aware of any recent risk behaviours or changes in care plans.

The unit had an identified police liaison officer and staff reported an effective working relationship. Staff reported in relation that police investigations could be lengthy and at times they did not receive feedback as to the outcomes of these.

Systems were in place for staff to regularly meet with the local commissioners that funded people's care. Specialist commissioners from NHS England met with senior managers as required.

Adherence to the MHA and the MHA Code of Practice

91% of hospital based staff had undertaken MHA training.

The units had clear procedures in place regarding their use and implementation of the Mental Health Act and the Mental Health Act code of practice. Advocates were available to people on the ward and most people we spoke with told us they were aware of their rights.

We found that the statutory systems were in place for planned and emergency admissions and the records seen showed us that people had been informed of their rights of appeal against their detention. We found systems in place for staff to produce statutory reports where people had appealed against their detention to first tier tribunals and hospital managers' hearings.

We reviewed the information provision available to the informal patient regarding their rights to leave the ward and saw that satisfactory arrangements were in place

Good practice in applying the MCA

91% of staff were trained in the Mental Capacity Act 2005 training including training relating to Deprivation of Liberty Safeguards (DoLS).

We saw that the provider had systems in place to assess and record people's mental capacity to make decisions and develop care plans for any needs. Most staff demonstrated awareness of the Act.

Are long stay/forensic/secure services caring?

Most people told us that staff were approachable and they gave them appropriate care and support.

The provider had systems to encourage people to be involved in their assessment, care planning and reviews through use of recovery tools such as 'My Shared Pathway'. People had the opportunity to attend a hospital based 'Service user forum'.

We found that people who used the service were treated with dignity and respect.

Kindness, dignity, respect and support

People told us that staff were kind and caring. The hospital director told us there was an identified staff dignity champion for the hospital. This person provided leadership and guidance to front line staff about the importance of maintaining the dignity of others at all times.

When we observed meetings, we found that people were informed of meeting times and the MDT gave explanation for involving people. We observed and heard staff communicating in a way that enabled people to understand and contribute meaningfully to the process.

Staff were familiar with the needs of the person being discussed. We found that people were involved in decisions about their risks assessments and management plans. We saw that staff were planning a community discussion about treating others with dignity and respect.

The involvement of people in the care they receive

We found evidence where people's strengths and views were identified in their care plans. For example their interests and things they wanted to achieve. We saw that care plans reflected the individual's person's needs and choices as far as possible.

We found that some paper care plans in files were not signed. They were in very small print and it was not clear if an easy read/large print format was available

Good

Long stay/forensic/secure services

We received mixed views from people about their involvement in their care planning. For example, on Audley ward two people told us they were not involved in their care planning and did not receive copies of their care plans. However, on Maldon ward people told us that they felt involved in their treatment and supported in making decisions about their care and had a copy of their care plan which they kept securely in their bedrooms.

We observed that staff spoke about people who used the services with respect. Staff spoke about people using the service in a positive and caring way and were motivated to ensure that people who used the services were safely cared for.

On Danbury ward we observed staff conversations about how they planned to involve and engage people in decisions about their treatment and sourcing internet information to give to people to help them understand their mental health.

Where we observed ward meetings we saw active involvement and participation from both staff and people who used the service. People were encouraged to chair their own meetings and supported in minute taking. Most people told us that they had regular contact with their families and friends. Solicitors and independent advocates were available for people.

Ward notice boards displayed information for people about treatment choices and included opportunities for them to meet and to discuss their medication with the hospital's pharmacist.

Are long stay/forensic/secure services responsive to people's needs?
(for example, to feedback?)

We saw evidence in people's care and treatment records of how the service had reviewed and amended treatments in order to meet their changing assessed needs. We reviewed some good examples of responsive care during the inspection.

A Quality Network for forensic mental health services, peer and self-assessment inspection had taken place on the low secure wards during May 2014 with identified good practice and areas for improvement. We noted that the provider had already taken actions to address an area identified for improvement.

There were opportunities for people to learn or maintain their skills and independence to the level they felt they were able to manage.

People's physical health needs were being appropriately monitored with regular checks completed. Chaplaincy information was displayed on wards.

Information about how to make a complaint was clearly displayed on the ward noticeboards for people to read. People told us that they felt well supported by staff in making complaints.

Complaints and concerns raised were discussed at the monthly 'Patient Safety and Experience Group' meeting to ensure that actions were completed and responses and feedback sent to people in a timely manner.

There was evidence of site developments to respond to people's assessed needs.

Access, discharge, and bed management

The hospital director told us that length of stay varied for wards. For example, the average for Maldon was 13 months and Danbury 9 months. As of 09 September 2014, there were 10% of people with a delayed discharge, waiting for beds elsewhere. This was supported by those records reviewed.

People were sometimese moved to alternative wards that were not always best suited to their needs. We spoke to senior staff about this and were informed that careful consideration was given by the multi-disciplinary team when deciding if someone needed to be transferred to another ward and their best interests were considered.

The provider was responsive to people and commissioner's needs. A project had been undertaken to investigate whether a neuropsychiatry service was needed and more recently managers had been assessing if there was a need to develop a male PICU.

On Danbury ward there was a mix of people with contrasting needs as some people required long term care. Some people had been in the hospital for over five years.

One person told us, "Very few people get discharged and people give up." We found that some people were newly transferred from prison and they presented as more acutely unwell than the other people on that ward.

There were identified care pathways for people admitted to Danbury or Hadleigh wards then they would move to Easton Lodge as part of their transition out of secure services. Staff told us that they carefully assessed people for the move to the open rehabilitation unit, this ensured the appropriate mix of people as it was a small house. There could be times when there were vacancies. Delays sometimes occurred for people due to issues with funding approval.

There were opportunities for people to learn or maintain their skills and independence to the level they felt they were able to manage. For example, people could carry out laundry, cooking, money management and travel by public transport. If people were unable to do any activities of daily living staff supported them. At Easton Lodge this was evident as the environment was more domestic and less like a hospital. Staff supported people as required with shopping and budgeting.

On Hadleigh ward staff told us that there was a waiting list for admission and the ward was full during our visit. The hospital director told us that staff tried to assess people within 48-72 hours of referral.

A staff member told us that at times unsuitable referrals were made and people were admitted with complex needs from prison. We learnt that a serious incident took place where the police had to be called to assist staff to manage a situation. A serious investigation (SI) took place to identify learning points and lessons and we received assurances that the findings would be discussed at the patient safety and experience group.

The ward environment optimises recovery, comfort and dignity

Clinic rooms were available on all the wards apart from Maldon Ward. Medicines and clinical equipment was stored in the ward office on this ward and people had to receive their medication or any treatment they required there. On the day of the inspection we observed this and found that people's dignity was compromised as they were constantly interrupted with staff coming and going from the office, other people knocking on the office door requiring assistance and the telephone ringing.

People could be seen through the large office window receiving their medications. People told us that they did not like being observed and that it made them feel uncomfortable. Staff told us that they had suggested to management that an unused room on the ward could be converted into a clinic room but as yet this had not been agreed.

There were identified areas for people to have visits with family, friends or professionals for privacy. There was a designated visitor's room outside the secure perimeter in reception. Staff told us that refurbishment plans were in hand to provide a specific child friendly room.

Each ward had a private room where people could make telephone calls. On Easton Lodge people had access to mobile phones and told us they had regular contact with family/friends.

There was a garden allotment where people and staff could grow fresh produce. However when we visited, people were not interested in using this. Groups promoting healthy eating took place. People had access to the onsite gym and could meet with the fitness instructor to discuss their needs. A number of people told us how much they enjoyed the gym facilities.

A patient information folder gave information relating to recovery such as local resources. Each person received a copy of their weekly activity planner which contained information such as their scheduled therapeutic activities, leave from the hospital grounds and ward meetings. Information on advocacy, the complaints process and Mental Health Act (MHA) rights was available to read on the ward noticeboards.

People told us that they could access cold drinks when required but that hot drinks were only available hourly. Some people told us that they were not happy to have to wait for a hot drink at night.

Each ward had direct access to a garden. These were well maintained and provided seating as well as a smoking shelter for people to use.

Ward policies and procedures minimise restrictions

We saw that people could personalise their bedrooms. For example, people had posters on their walls and photographs in their rooms.

Good

Long stay/forensic/secure services

On Easton Lodge people who were not detained under the Mental Health Act had signed agreements/contracts stating they would abide by the rules of the hospital. These included not bringing or consuming drugs/alcohol on site, telling staff where they were going on leave and returning by a specified time. We saw the people had access to significant periods of leave as part of managing their transition from hospital to community.

Meeting the needs of all people who use the service

Chaplaincy information was displayed on wards. We saw systems for staff to undertake spiritual assessments with people, for example at Easton Lodge.

The provider had timetables to offer people a weekly minimum of 25 hours therapeutic activity and for tracking attendance. The lead OT told us that people had an individualised activity timetable for the week. This had 'essential' activities to attend and for most wards there was a payment incentive scheme. The lead OT told us that people were given a copy of the range of activities available and then chose what they wanted to attend. This was then negotiated with the MDT and agreement gained for their activities timetable. Activities were provided by the multi-disciplinary team, in addition to therapy sessions, some were leisure or community based. There was a mixture of closed and 'open' groups where people could attend when there was vacancy or had leave granted.

Some activities focused on the social inclusion of people such as adult education and vocational services for example "dog walking". People were supported as appropriate to get passes to use local amenities such the buses, library or gym. Library and computer facilities were available onsite and there was a visiting mobile library.

If a person required assessment from an OT for physical health issues, for example if they had mobility difficulties, this was requested from the central Northampton site and if any equipment was required then the person's local commissioners would be contacted for funding. Staff told us that this process often caused delays in accessing the required equipment that was needed to support people in their daily living. For example, on one ward we saw that a person had been without their mobility aid for over a week due to a fault with the equipment. This was bought to the attention of senior staff on the unit concerned.

Some people told us the food was good. Food was prepared on site and people could choose from a menu.

The provider had systems to assess and monitor the quality of the service and gain feedback. Access to the ward kitchen was restricted due the risks people could pose to themselves or others. There were identified meal/hot drink times.

Listening to and learning from concerns and complaints

During our visit, three people raised concerns with the inspection team about issues (not solely related to the provider and this core service) and we passed these on to senior staff who confirmed that these would be investigated in line with their complaints procedures.

Information about how to make a complaint was clearly displayed on the ward noticeboards for people to read. People told us that they felt well supported by staff in making complaints.

Complaints and concerns raised were discussed at the monthly 'patient safety and experience group' to ensure that actions were completed and responses and feedback sent to people in a timely manner.

Are long stay/forensic/secure services well-led?

We found that the provider provided information to staff and people about their service in different and effective ways. Most staff were aware of the provider's core values.

The provider had a governance framework in place at this location with links for feedback to/from the central site at Northampton. For example we noted that 'out of hours' visits by senior staff and unannounced visits from directors took place with reports on the quality and experience of care provided.

Most staff reported support from their manager. They told us they undertook training and had supervision, team meetings and appraisals to ensure they were competent and confident in their role. Most staff reported managers were approachable and they were effective leaders.

There was no manager in place for Danbury ward.

People and staff were encouraged to give feedback on the quality of the service in various ways such as meetings and surveys.

Good

Long stay/forensic/secure services

Vision and values

Information about the provider's vision and values were displayed across wards. Staff were kept informed of developments via email and the intranet. Staff reported contact with senior managers in the organisation and that these managers have visited the ward areas. Quarterly staff briefing meetings were held with the hospital director.

Good governance

We found that there were governance systems and meetings at the hospital and within the organisation to review and report for example on incidents, audits and complaints and develop plans for actions needed. Lead staff reported links with managers/peers at other St Andrew's healthcare locations with opportunities to visit have telephone/video conference.

Staff told us that they felt supported in reporting incidents and that lessons learnt were discussed in both individual supervision sessions and within team meetings. 'Think back, move forward' forms were completed by the patient with staff support following an incident. This assisted in reflective thinking and practice.

There were staff resources to deliver training on site and via 'e learning'. Staff reported receiving appraisals. There were systems for staff to receive professional supervision. For example, nursing staff could receive'30:30' managerial supervision (30 minutes every 30 days). Staff referred to 'reflective practice' sessions taking place where staff had the opportunity to discuss with their peers any issue or concerns about people they were working with.

There were opportunities for staff to undertake specialist training as relevant for their work such as emergency and relational security training detailing their role as escort, carrying out observations and search training. Training took place for reducing the risk of self-harm and suicide. We saw that some professionals had opportunities to be involved in learning and development outside of the organisation such as being the chairperson for the specialty doctors committee at the Royal College of Psychiatrists.

Some staff across these wards told us that they considered that there was too much paperwork/bureaucracy which they felt was being cascaded from the central site without understanding how it impacted on the staff and their ability to work with people.

Leadership, morale and staff engagement

Most staff reported receiving good support from line managers and peers. Comments from staff included "it's fantastic, and they [managers] are really supportive". Another "I am happy working here." Another said they got, "exhausted." We noted an increase in staff reporting this in the staff satisfaction survey 2014. Some staff told us that the provider's focus was on "making money." Some senior staff reported a, "controlling organisation" with little ability to influence and to, "bureaucratic processes" within the organisation.

Senior staff told us approximately 60% of people on sick leave were long term and the rest short term. Some staff told us they had been on sick leave within the last three months. The staff survey results reviewed showed that the percentage of staff that reported a slight increase in their health suffering because of work had increased by one percent.

We saw that the provider had systems to refer staff to an occupational health service for advice and support as relevant before returning to work. Staff reported mixed feelings to the level of support they received from management following their return from sick leave.

Staff told us some managers were managing more than one ward and this affected their availability and effectiveness. We saw that management and leadership training was available to staff.

We saw evidence of regular individual supervision meetings and team meetings for staff. Staff told us that they felt their individual supervision meetings were valuable and gave them protected time to discuss personal development and any concerns or issues that they may have. Staff told us that bureau staff did not receive supervision in this role for the provider.

Staff reported they had met with the hospital director at "ask the director" sessions were they could attend and put their views across.

Examples of additional staff feedback systems were when a staff member received a handwritten thank you letter from the chief executive officer acknowledging their work. A senior staff member told us there were 'thank you cards' that could be sent to staff which they had recently used.

A healthcare assistant forum was being developed for the unit and staff were undertaking mentorship training to lead this and support their peers.

Staff referred to case studies taking place where staff had the opportunity to discuss with peers any issue or concerns about people they were working with.

Staff reported that they had been able to raise concerns with managers. For example, they disagreed with staff working long shifts and had been given feedback about the rationale for this. Staff were aware of the whistleblowing policy and told us that they knew how to raise any issues through this process or anonymously via the provider's 'safe call' system.

Most staff reported good peer support. However on Danbury Ward, there had not been a ward manager in post since May 2014. Staff told us that there had not been consistent leadership of this ward despite some managers covering at times.

Staff told us that the high use of agency staff across the wards impacted on team working and this put pressure on the regular staff. Some staff informed us told us they had not received management supervision. However, another staff member told us that they had opportunities to meet directors, executive board members and other visitors to the unit which they felt was valuable.

Commitment to quality improvement and innovation

The hospital director told us they received weekly reports on the quality of the services provided. Key performance indicators and other systems were available at ward meetings for staff to gauge their performance in comparison to other wards in the unit for example for safeguarding, incidents, complaints and absence without leave (AWOL). Information was analysed and also aligned in five domains (safe, effective, caring, responsive and well led).

Out of hours visits by senior staff and unannounced visits from directors took place. We saw reports on the quality and experience and these were fedback to the hospital and to the ward visited**.** Senior staff from wards and department attended quality and compliance groups and action plans were displayed in the unit.

We reviewed the latest staff survey results for the hospital and dated February 2014. This demonstrated to us an increased overall staff satisfaction in most areas. However, we noted that staff reported overall no improvement with communication with senior management.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **How the regulation was not being met** The provider had not ensured that the ligature risks identified on Audley ward were risk assessed and addressed. Regulation 15 (1) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **How the regulation was not being met** The provider had not ensured that all assessment and treatment records for people who used Maldon Ward were accurate and fit for purpose. Regulation 20 (1) (a).