Tees, Esk and Wear Valleys NHS Foundation Trust

Forensic inpatient or secure wards

Inspection report

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Date of inspection visit: 4 July - 2 August 2022
Date of publication: 28/10/2022

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Forensic inpatient or secure wards

Requires Improvement 

We carried out this unannounced focused inspection to see whether improvements had been made since our last inspection in June 2021. On that inspection, we issued a warning notice under Section 29A of the Health and Social Care Act.

On this inspection, we checked whether improvements had been made to address the concerns identified. These included ensuring that; there were enough staff so that care and treatment was delivered in a safe way, patients were safeguarded from abuse and treated with kindness, dignity and respect, staff were appropriately trained, the use of restraint within the service was proportionate and individualised, incidents were being reported in line with the trusts incident reporting policy, staff attended regular team meetings and received regular supervision and patients had access to activities and psychological interventions. This is in line with our published guidance to follow up inadequate ratings and section 29A warning notices. Our overall rating of the service improved. We rated them as requires improvement because:

- The service did not always provide safe care. The wards did not have enough nurses to carry out all clinical duties to meet the needs of the patients. The service did not always have enough staff to provide a timely response to patient safety incidents. There were not always enough staff who knew patients well to keep patients safe.
- The service did not follow good practice with respect to safeguarding. Staff did not always make safeguarding referrals when appropriate and governance processes were not adequate to identify improvements in this area.
- Staff did not always assess and manage risk well. Not all ward environments were safe, clean and fit for purpose.
- The service was using restrictive practice that was not care planned for or reviewed in line with trust policy. Restrictions were not always based on individual risk assessments and there were blanket restrictions in place. When patients were in seclusion, staff did not always complete required reviews in line with the trust policy or best practice as outlined in the Mental Health Act Code of Practice.
- Staff did not always report and record incidents appropriately. Staff did not always report incidents when they occurred and sometimes reported multiple incidents within a single incident record. This meant that there was not appropriate oversight of the scale and nature of incidents which were happening within the service.
- Staff did not ensure that patients' health was appropriately monitored, in relation to high dose antipsychotic treatment, blood glucose and where appropriate bowel monitoring.
- The service provided a range of treatments, but staffing levels meant that patients did not always have access to activities, psychological interventions, occupational therapy or escorted Section 17 leave, and staff could not always take their breaks. Staff could not always engage in clinical audit to evaluate the quality of care they provided due to staffing pressures.
- Managers did not ensure that regular team meetings took place on all the wards within the service to ensure key information was shared and escalated.

Our findings

- Managers did not always ensure staff had the correct skills and experience to work on mental health and learning disability and autism wards. Managers did not ensure that temporary or unfamiliar staff received a comprehensive induction before working on the wards or that staff received mandatory and statutory training and regular supervision.
- Staff did not always treat patients with compassion, kindness and respect.
- Staff did not always plan discharge well or liaise well with services that would provide aftercare. As a result, discharge was delayed for other than a clinical reason.
- The service was not always well led, and the governance processes did not ensure that ward procedures ran smoothly.

However:

- The service used systems and processes to safely prescribe, administer, record and store medicines.
- Staff mostly understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment.
- The ward teams had access to the range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team.
- Staff actively involved patients and families and carers in care decisions. Staff supported patients well to live healthier lives.
- Culture within the service had improved since out last inspection, staff felt more supported by managers and mechanisms had been put in place to allow staff to escalate staffing concerns.

What people who use the service say

We spoke to 34 service users and their families during our visit. Feedback from them was mixed.

Fifteen patients we spoke to raised concerns regarding there not being enough staff on the wards. Patients told us staff spent a lot of time in the office which sometimes made them feel neglected. Two patients told us that they had not received their prescribed medication on the day we arrived due to staffing. Another patient told us they did not know who their key worker was. However, most patients said that staff were caring towards them.

In the last patient satisfaction survey completed, the average satisfaction score across the service was 75%. Out of 109 comments received, 64 were negative and 30 were positive.

We spoke to 10 families of service users who told us they felt involved in the care of their relative. However, most families raised concerns related to staffing impacting on the continuity of care for their relative and the ability to facilitate patient leave. Half of the families told us they were unaware of any discharge planning.

From the most recent surveys filled out by family, carers and friends the average satisfaction score across the service was 61%.

Our findings

Is the service safe?

Inadequate  

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

Not all wards were safe, clean, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated risk assessments of ward areas and removed or reduced most risks they identified. The turning mechanism on bedroom door viewing panels on Sandpiper ward protruded from the door. This had been identified as a risk to service users following several patient safety incidents. The service had recognised this issue but had not yet removed the risk.

Staff could observe patients in most parts of the wards using CCTV or placement of staff.

The service complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had access to alarms and patients had easy access to nurse call systems. However, not all wards used the same alarm system which meant that site wide response to incidents could not be facilitated across all wards, if required. The service had plans in place to update all alarms within the service by September 2022.

Maintenance, cleanliness and infection control

Most ward areas were clean and well maintained, Osprey ward appeared dirty with old coffee stains, litter and crumbs on the floor throughout the ward. Ivy ward also appeared unkempt with dirty carpets and crumbs on the floor throughout the communal area.

Most wards were well-furnished and fit for purpose. Brambling and Mandarin wards contained very bright lighting throughout the communal areas and bedrooms that were controlled by a movement sensor, this meant that the ward environment was not therapeutic, and the lights disturbed service users during the night. The door to the quiet area on Brambling ward did not contain windows to allow observation, meaning patients could not access the area without staff.

Staff followed infection control policy, including handwashing.

Seclusion room

The seclusion rooms allowed clear observation. The two-way intercoms in the seclusion rooms were loud and echoey, due to this they were rarely used which meant communication between the patient and staff could be difficult. The seclusion rooms all contained a toilet and clock, except for Fern ward where there was no clock on display, this was escalated and addressed during the inspection.

Our findings

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing staff within the service and relied on bank and agency staff, who did not always know the patients to keep people safe from avoidable harm.

Nursing staff

The service was running on a business continuity arrangement due to staffing pressures, and continuously only had the minimum level of nursing and support staff available to keep patients safe. Managers had calculated and reviewed the number and grade of nurses and healthcare assistants for each shift, known as their staffing establishment, levels. Staffing levels were based on a traffic light system. Green meant that wards were at full establishment, amber indicated wards were at minimum safe staffing levels and red where wards were unsafe.

The service did not have systems in place to easily review previous staffing levels that fell below their minimum level. The trust provided staffing data for an eight-week period between 1 May 2022 – 30 June 2022 which showed that wards were regularly falling below minimum staffing levels. After we escalated concerns about the staffing data, the trust confirmed the data provided was not accurate and that at least one qualified nurse and support staff had been deployed on each ward during the reporting period. We returned to the service to view the electronic system used by managers in the service. We could see that managers had daily oversight of staffing levels for each ward, although these were continuously falling below the green established staffing levels.

All the staff we spoke to raised concerns regarding staffing levels and the effect it had on the staff team and the service users. Staff told us it was very rare that they would have the full complement of staff available on the wards. Ward managers, modern matrons and allied health professionals were regularly being deployed onto wards to meet minimum staffing levels, and the service was relying on bank and agency staff to maintain patient safety. Staff were frequently being moved to different wards during their shift based on risk, which meant they were often working in environments and with patients they were unfamiliar with.

This was impacting on several areas within the service; incident data showed staff were not always able to provide a timely response to incidents. Staff were unable to carry out all clinical duties on time, such as administering medication and completing clinical audits. Staff were regularly unable to take their breaks off the ward. Patient's hospital ground leave, Section 17 leave (permission to leave the hospital) and visits from friends and family were being cancelled daily at short notice. Patients told us they felt neglected and did not have enough time with staff. Carers we spoke to highlighted staffing pressures as a concern and felt it was impacting on patient's continuity of care and their ability to visit their loved ones.

The wards did not always have enough staff each shift to carry out physical interventions safely. Where wards were short staffed or did not have trained staff available on the ward, staff would press their alarms and await assistance from the allocated response team. This caused a delay in managing incidents. Staff on Newtondale ward told us that delays were often an issue for them due to the ward being located outside of the secure perimeter of the other wards. Staff on Mandarin and Swift ward also reported delays in staff responding to incidents. There were plans In place at the time of the inspection for Newtondale to move within the secure perimeter.

Our findings

The service had high vacancy rates with 35.63 qualified and 5.27 HCA (WTE) vacancies. However, ongoing recruitment campaigns were in place to employ more staff.

The service used high rates of bank and agency nurses, and nursing assistants. In the 12-month period from July 2021 – June 2022, 8301 shifts were filled by bank or agency staff.

There were no processes in place to request bank and agency staff that were familiar with the service. Management did not have plans in place to ensure that temporary staff would be allocated to familiar wards, or that permanent staff would not continue to be moved to wards they had not worked on.

Managers made sure all bank staff had a full induction. Agency staff and staff unfamiliar to a ward relied on a 'rapid' induction which included a handover of basic information including patient and environmental risk, and fire safety information.

The service had maintained a turnover rate of 11% in the last 12 months. Levels of sickness had increased in the last 12 months, the average sickness rate in June 2022 was 16%. Managers supported staff who needed time off for ill health.

The service had a system in place which allowed staff to escalate staffing concerns, the system was updated in real time which automatically highlighted the wards most at risk throughout the service. This was overseen and managed by an allocated duty nurse coordinator for the shift. The duty nurse coordinator could adjust staffing levels across the wards according to patient risk. However due to overall staffing levels this often negatively impacted on the availability of therapeutic activities within the service. This was because staff were utilised in other ways in order to address and mitigate risk.

Patients did not have regular one to one sessions with their named nurse and patients told us staff spent a lot of time in the office. One patient on Kestrel/ Kite ward told us they did not have a named nurse. Patients frequently had their Section 17 escorted leave or activities re-arranged or cancelled. We spoke to 24 patients during our inspection, 15 of whom raised concerns relating to staffing levels.

Managers had recently introduced a 'leave team' to the service to enable them to facilitate more Section 17 leave for patients. Staff were positive about the team and told us this had recently increased leave off the ward, but meant patients were being accompanied by unfamiliar staff. Managers told us they had recruited more staff into the leave team and had plans to allocate members of the team to a group of wards for consistency.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The service managed this using a traffic light system. The nurse in charge would ring the doctor if required and fill in a form with information. Visits to patients would then be triaged and prioritised based on risk.

Managers could call locums when they needed additional medical cover.

Mandatory training

Staff had not always completed and kept up to date with their mandatory training. Overall training compliance for the service was 88%. However, the following training courses fell below 75% compliance:

- Intermediate life support training at 56%

Our findings

- Positive and safe care level 2 at 70%
- Face to face medication assessment at 57%
- Learning disability and autism training at 69%

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. Staff had the skills to develop and implement good positive behaviour support plans and most staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using an in-house tool. We reviewed 13 care records, all care records included up to date, detailed risk assessments which had been regularly reviewed and updated following incidents. However, we identified through meeting minutes that a patient on one ward had made staff aware that they did not want male staff to carry out their observations during the night, due to past trauma. Staff on the ward had not updated the patient's risk assessment and safety plan to reflect this or taken any action to ensure only female staff would carry out their observations.

Management of patient risk

Staff knew about risks to patients they were familiar with. Staff shared information to keep patients safe during daily handovers, however information regarding patient risk was limited in three of the five handovers we observed. The handover documentation for patients on Mallard and Mandarin wards lacked detail regarding patient risk. On Nightingale ward the handover documentation was not filled in for seven of the 15 patients. In addition, where patients were on enhanced observations on Nightingale ward, documentation was not dated and information regarding their associated risks for enhanced observation was not included.

Staff applied restrictions which were not always proportionate to the level of individual patient risk. There were blanket restrictions in place on some wards. This included restricting patient access to bedrooms on four wards, restricted access to drinks and snacks on seven wards and restricting patient access to the courtyard on one ward.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff followed procedures to minimise risks where they could not easily observe patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

We compared restrictive intervention data from January – March 2021 and January – March 2022 and found levels of restrictive interventions had reduced.

Our findings

Incident data provided by the trust for the period between 9 May 2022 – 3 July 2022 showed that seven patients were being restricted from accessing their bedroom across four different wards. The trust notified us that there was only one patient within the service who had a bedroom access plan in place. This meant that for the other six patients, restricted access to their bedroom was not being assessed and reviewed in line with the trust restrictions policy.

Incident data showed that staff used prone restraint six times within the reporting period, the trust told us following the inspection they had commenced a review of CCTV of all these incidents.

Staff attempted to avoid using restraint by using de-escalation techniques and mostly restrained patients only when these failed, and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records of their time in seclusion. However, incident data between 9May 2022 – 3 July 2022 showed that seclusion reviews had been delayed or had to take place over the phone due to staffing levels on six occasions. One patient did not receive a nursing review for six hours. This is not in line with the trust policy or best practice as outlined in the Mental Health Act Code of Practice.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

Safeguarding

Staff had a basic understanding of how to protect patients from abuse. Staff displayed little confidence and knowledge of how to escalate safeguarding concerns to external agencies to keep people safe. Staff had training on how to recognise and report abuse, but our findings did not evidence that they knew how to apply it.

At the time of our visit the trust did not have an adults safeguarding policy in place. The staff were using a one-page procedure which contained links to guidance, the links embedded within the guidance did not work and were not easily accessible to staff. Managers were unaware that the links did not work or how long the guidance had not been easily available. The trust ratified and published their safeguarding adults' policy following our visit. Managers did not have a plan in place to ensure that the new policy was shared and embedded amongst staff.

Staff were up to date with their safeguarding training. The overall training compliance for the service was 93%. However, aside from escalating concerns internally to the trust safeguarding team, 11 out of 14 staff could not give clear examples of how to protect patients from harassment and discrimination or how to make a safeguarding referral to an external agency.

The reporting and documenting of safeguarding referrals was inconsistent across all wards. We reviewed 19 care records in relation to safeguarding and found that nine showed evidence of safeguarding processes not being followed appropriately, and in line with the trusts safeguarding adults' procedure. The safeguarding lead within the service told us they had recognised improvements could be made with regards to staff confidence and documentation. However, aside from individual supervision there were no formal plans in place to address this service wide.

Review of care records and incident data showed evidence that patients had been exposed to or were at risk of harm without the appropriate safeguarding referrals being made, either internally, or to an external agency.

Our findings

For example, we reviewed a care record that detailed a patient alleging to staff that they had been sexually abused by another patient three days prior to our inspection. This had not been logged as an incident, reviewed by staff or referred to safeguarding. Managers told us this would be used as an example of learning and would be included in future training, however a quarter of staff were not allocated to complete the training for up to six months and managers had not taken any immediate action to share learning across the service.

Incident data also showed that staff had threatened to remove a patient's Section 17 leave if they did not behave as requested by the staff. One carer told us that they felt patient leave was also used as a threat over their relative.

We also observed staff referring to a patient inappropriately during handover, describing them as a 'nightmare'.

The trust had implemented a new safeguarding lead role within the service who supported the wards directly three days a week. Staff knew who the safeguarding lead was and how to contact the duty safeguarding team, if required. The safeguarding team had recently implemented safeguarding supervision for staff within the service, however managers within the service were unable to evidence the impact of this at the time of our inspection.

The safeguarding dip sample checks in place to ensure patients were being safeguarded appropriately were not robust enough to ensure that improvements were identified and implemented. Since November 2021 the service had only conducted a random sample of 20 incidents across all wards. This was escalated to managers during our inspection who outlined a plan to increase sampling as a result.

The trust had processes in place and followed clear procedures to keep children visiting the service safe.

Staff access to essential information

Clinical information was not always easily accessible to staff. Staff used a mixture of paper-based and electronic records. Staff found their systems difficult to navigate and some clinical records were hard to locate.

Patient notes were comprehensive; however, staff could not access relevant documentation easily. When staff needed to save important clinical information on the system, they were restricted in naming word documents as 'blank letter template'. This meant staff had to open all the documents to find the information they were looking for. Staff told us this was time consuming and made it difficult to locate certain patient information.

Fern ward was experiencing issues with generator testing which meant that all power to their computer systems would go off unexpectedly. Staff told us that this could happen when they were in the process of inputting notes and they had lost essential information they have entered on to the system. Staff told us they had raised this as a concern with management but there were no plans in place to address it. The problem had been occurring for over 12 months at the time of our visit.

Where paper documentation was used in the office to detail patient risk and care plans, this was not as up to date as electronic information.

When patients were transferred to a new team, there were no delays in staff accessing their records. All wards within the service used the same system and could access the same information.

Records were stored securely.

Medicines management

Our findings

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff did not always regularly review the effects of medications on each patient's mental and physical health.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medicines were reviewed regularly by the multi-disciplinary team. Patients were supported to self-administer medicines as part of their rehabilitation. Large format compliance sheets were provided to one patient to assist them in remembering when to take their medicines. Patients were able to request consultations with the pharmacy team to discuss their medicines.

Staff completed medicines records accurately and kept them up to date. Prescription charts were completed in most cases in line with the providers policy. Appropriate non-administration codes were used in most cases and these were picked up as part of the daily audits. Pharmacy reviews were clearly documented on the prescription charts and each ward had weekly reviews. Daily audits of administration documents were completed to gain assurance that medicines were being administered correctly.

Staff stored and managed all medicines and prescribing documents safely. Treatment rooms were clean and tidy; medicines were stored securely with access restricted. Pharmacy teams completed medicines optimisation audits regularly and controlled drugs audits quarterly. Small portable oxygen cylinders were not always stored securely in line with guidance.

Staff followed national practice to check patients had the correct medicines when they were admitted or moved between services. Staff liaised with patients' previous services to ensure accurate transfer of medicines information. At the point of discharge pharmacy teams supported patients and community teams providing information about medicines.

Staff learned from safety alerts and incidents to improve practice. Staff described the process they would follow in the event of a medicine's incident being found. Medicines incidents were reviewed centrally by the medicines safety officer who shared themes and trends with staff teams for ongoing learning.

Staff ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We found no evidence of inappropriate use of medicines, the service proactively de-prescribed medicines to ensure patients were taking the minimum needed for maintaining their stable health and wellbeing. We saw clear rationale to why dose reduction regimes were being prescribed and how these were monitored and managed for people taking benzodiazepines and controlled drugs.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. The provider had a dedicated primary care service which supported patients with their physical health. This included all aspects of physical health including vaccinations, asthma, cervical smears, hypertension and aspects of blood monitoring. Ward based monitoring forms for high dose antipsychotic treatment (HDAT), diabetes and (where appropriate) bowel monitoring were not always completed in line with provider policy or in line with intervention plans. We saw examples where blood glucose levels had exceeded the expected ranges, but no documented actions had been taken. For another person blood glucose was to be checked twice daily however, changes to frequencies of monitoring had been made but not documented, meaning records were not accurate. Bowel monitoring charts on Brambling ward were completed routinely and reviewed regularly however this was not the case on the other wards which posed a risk to some patients' health and wellbeing. HDAT forms were not completed in line with the trust policy across the service, we could therefore not be assured that for those patients receiving HDAT that monitoring was being completed and reviewed to keep people safe.

Our findings

Track record on safety

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always report incidents in line with the trusts incident reporting policy. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff told us they knew what incidents to report and which system to report them on. However, we reviewed 13 patient care records and found examples of six incidents across three wards that had not been reported in line with the trusts incident reporting policy. We also reviewed incident data from 9 May – 3 July 2022, from 631 incidents reported, 14% of incidents had not been reported appropriately and in line with the trusts' incident reporting policy.

Staff were recording multiple and different types of incidents over a 12-hour period in one incident report. For example, patient safety incidents were being combined with staff assaults and damage to property and therefore not categorised correctly, and incidents of restraint were being grouped into one report. Managers told us that staff could include up to 14 incidents of restraint in one incident report, however this did not form part of their incident reporting policy.

Incident data showed that on four occasions when either staff or patients had attended Accident and Emergency due to injury, this had been recorded as a 'no harm' incident.

The trusts incident reporting policy was due to be reviewed in September 2021 which had not taken place.

Staff reported serious incidents clearly, however incidents were not always reviewed in line with the trust serious incident policy timescales. There had been five serious incidents within service between April 2021 – March 2022. The comprehensive serious incident review reports, which included areas for improvement, had been delayed due to a backlog of incidents awaiting review, this meant that identifying areas for improvement and sharing learning was delayed. Rapid reviews had taken place following all serious incidents.

Managers did not always debrief and support staff after serious incidents. We spoke to 21 staff regarding incidents and only five members of staff told us that debriefs took place. None of the staff could give examples of any improvements made following the five serious incidents that had taken place within the last 12 months and none of the staff we asked could give details of any recent serious incidents.

Managers investigated incidents; however, investigations were often delayed due to staffing pressures. Patients and their families were involved in these investigations.

Managers within the service held regular meetings in which safety improvements were discussed, however, most staff told us they only received feedback from investigation of incidents through online bulletins and emails, both internal and external to the service. Incidents were not included as a standard agenda item in team meetings, and team meetings did not take place regularly across all wards.

There was some evidence that changes had been made as a result of feedback. Eleven of the 21 staff we spoke to were able to provide examples of safety improvement being made within the service. For example; two ward managers told us that senior management within the service had recently identified a rise in missed signatures when administering medication. Clinical staff were provided with a red tabard to wear when issuing medication to prevent colleagues from disturbing them whilst carrying out this work, to try to reduce errors within the service.

Our findings

The service had no never events on any wards.

Most staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if, and when things went wrong.

Is the service effective?

Requires Improvement 

Our rating of effective improved. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, but did not always include the patient voice. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed 13 care records and saw evidence of mental health assessments taking place for most patients. We were unable to locate original assessments on the electronic system for four patients due to the length of their admission and it being difficult to find them on the system. The trust told us these reports had been archived.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery orientated, however five care plans we reviewed contained no evidence of the patient voice.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment suitable for the patients in the service, including cognitive analytic therapy, dialectical behaviour therapy and cognitive behavioural therapy. However, psychologists, occupational therapists and art therapists were being deployed on to wards to support with staffing pressures which limited patient access to these therapies.

The psychologists within the service supported more than one ward, which created a waiting list for some patients. One patient on Swift ward had been waiting for psychology input for over three weeks.

Our findings

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. We saw good evidence of physical healthcare monitoring within all care records we reviewed. The service had a physical health centre hub on site and staff encouraged patients to manage and book their own appointments within the centre to support a transition into the community following their stay in hospital.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Care records showed evidence of patients being referred to speech and language therapists and dieticians to support their needs.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients had access to an onsite gym with personal trainers to offer support. We saw patients using the equipment during our inspection, who told us they found it beneficial. Managers within the service had recently organised a 5-kilometre run within the secure perimeter of the service and joined in with the run to encourage patients to take part. The dieticians within the service had also worked with the speech and language therapists to produce a recipe book of balanced meals for patients.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients. All wards had a computer which patients had supervised access to. The service had recently introduced the use of smart phones for patients, where appropriate, access to smart phones was individually risk assessed and reviewed for each patient. This enabled and encouraged patients to use technology to stay in touch with family, access information and do their own online shopping, where appropriate.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. However, not all wards were able to complete their clinical audits regularly due to staffing pressures and audits were not always effective. We found issues relating to blood, HDAT and bowel monitoring, incident reporting and safeguarding which audits had not picked up.

Skilled staff to deliver care

Although the ward teams had access to the full range of specialists required, they were not always able to meet the needs of patients on the wards. Managers did not make sure they had staff with the range of skills needed to provide high quality care. Most staff told us they felt supported; however, supervision was low across the service. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the wards. These included psychiatrists, speech and language therapists, dieticians and social workers. We saw an increase in occupational therapy sessions, group psychology sessions and art therapy taking place in the last 12 months. However, due to the service running in business continuity arrangements, some professions were being deployed to meet ward minimum staffing levels, which had impacted on patient care and activities and therapy sessions were sometimes cancelled.

Managers did not always ensure staff had the right skills and experience to meet the needs of the patients in their care, including bank and agency staff. Staff who did not have any experience or training outside of the trust induction were working on wards within the service. Staff working on learning disability and autism wards within the service did not always have the appropriate training and communication skills for the patient group. Staff had access to learning disability and autism training, however only 69% of staff had completed it.

Managers gave each new member of staff an induction to the service before they started work.

Our findings

Managers supported staff through regular, constructive appraisals of their work, the overall appraisal rate across the service was 86%. However, appraisal rates on Mandarin and Brambling ward were lower at 70%. The trust did not provide any appraisal figures for Mandarin ward.

Managers did not always support staff through regular, constructive clinical and managerial supervision of their work. The average managerial supervision rate across the service for January – June 2022 was 55%. The average clinical supervision rate for the same period was 77%.

Managers did not always ensure regular team meetings took place; team meetings were sometimes cancelled due to staffing pressures. We visited 14 wards and saw recent team meetings had taken place on four wards, Mandarin, Lark, Clover/Ivy and Northdale. We asked 21 staff members across 14 wards if monthly team meetings took place and only three staff across two wards (Mandarin and Northdale), said that regular team meetings took place.

Managers acknowledged any additional training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Specialist training was available for staff, staff were able to give us examples of specialist training they had completed such as; venepuncture, personality disorder, electrocardiograms, dialectical behaviour therapy and catheter care.

Managers recognised poor performance, they could identify the reasons and dealt with these. The trust had a performance management system in place which outlined the process for addressing staff performance issues.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Daily report out meetings were held with a multidisciplinary team to discuss patient care and recent incidents. However, health care assistants weren't routinely invited to report out meetings or weekly multidisciplinary meetings for the patient.

Ward teams had effective working relationships with other teams in the organisation and external organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The overall compliance rate in the service for Mental Health Act and the Mental Health Act Code of Practice training was 94%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew where the Mental Health Act administrators were based and how to contact them to ask for support.

Our findings

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated record correctly and staff could access them when needed, although some documentation was difficult to locate on the system.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005, but did not always assess and record capacity clearly for patients who might have impaired mental capacity.

Staff received, and were up to date, with training in the Mental Capacity Act and had a basic understanding. Overall compliance for Mental Capacity Act training was 90%.

There was a clear policy on Mental Capacity Act which staff knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff mostly assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. However, we reviewed two care records on Kestrel/ Kite ward which contained no evidence of the patient's capacity being assessed.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients, but did not always consider the patient's wishes, feelings, culture and history. We reviewed four care records on Kestrel/ Kite, Mallard and Mandarin wards which showed no evidence of this.

Our findings

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Requires Improvement 

Our rating of caring improved. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with compassion and kindness or respect patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were responsive when caring for patients. Most staff were respectful to patients; however, we observed staff using inappropriate language when describing patients during three handover meetings.

Patients said staff treated them well and behaved kindly. Most staff gave patients help, emotional support and advice when they needed it and respected the individual needs of each patient. However, patients told us they sometimes felt neglected due to staffing levels and staff spend a lot of time in the office, rather than engaging with them. One patient told us staff did not respect their privacy or knock before entering their room. Two patients raised concerns about male staff carrying out their night-time observations as it made them feel uncomfortable, staff had not taken action to support one of the patients with this. Incident data also showed one staff member using threatening language towards a patient in order to get the patient to behave in a way they wanted.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. We saw evidence in care records that staff had referred patients to social services, acute hospital services, opticians, dieticians, dentists and LGBT+ support services.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. However, when we requested a copy of a patient welcome pack for Clover/Ivy ward they did not have one in place.

Our findings

Staff mostly involved patients and gave them access to their care planning and risk assessments. We reviewed 13 care records and saw that 12 patients were offered a copy of their care plan.

Staff made sure patients understood their care and treatment, however the service had not been pro-active in finding ways to communicate with patients who had communication difficulties. Easy read care plans were not available for patients, where these were required.

Staff involved patients in decisions about the service, when appropriate. The service held community meetings with patients on the wards and the meeting minutes were available for patients to review if they did not attend. Patients from wards were also members of the service's united voices forum which allowed patients the opportunity to influence positive change within the service.

Patients could give feedback on the service and their treatment and staff supported them to do this. All wards we visited contained a 'you said, we did' board aside from Mandarin and Clover/Ivy wards. The service carried out patient experience surveys across the ward. Patients across 12 wards completed a survey between 1 July 2021 – 31 June 2022. The average satisfaction score across the service was 75%. Out of 109 comments received, 64 were negative and 30 were positive. The trust also had a complaints procedure in place and information on how to complain was available for patients.

Staff did not always support patients to make advanced decisions on their care. We reviewed 13 care records and could only see evidence of this in one care record.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke to 10 families who told us that they felt involved in the care of their relative. They told us they received monthly newsletters and were invited to away days and regular online calls. The recovery and outcomes team were holding monthly engagement sessions with carers and working with carers to develop their knowledge of the care being provided, the team had training sessions booked with carers to deliver training on trauma informed care.

Four carers told us that visits were rarely facilitated off the ward and were often be cancelled at short notice or delayed due to staffing levels. Two families raised concerns about high turnover of doctors within the service and said that this was impacting on continuity of care. One family told us their relative had five consultants in three years and another had three consultants in six months. Four families raised concerns regarding communication with doctors and being able to access information relating to their relative care. Six families told us they were unaware of any plans regarding their relatives' discharge, one family had specifically requested a discharge plan for their relative and had not received it.

Staff helped families to give feedback on the service. The service carried out surveys with friends and families. From the surveys filled in between 1 July 2021 – 31 June 2022 the average satisfaction score across the service was 61%.

Staff gave carers information on how to find the carer's assessment.

Our findings

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

Staff did not always plan and manage patient discharge well. There was little evidence to show that staff worked well with services providing aftercare, or managed patients' moves to another inpatient service or to prison well. We saw little evidence of collaborative working being documented in care records.

Bed management

The average bed occupancy rate was over 85% across seven wards from July 2022 – June 2021. The service was commissioned by the Provider Collaborative to achieve 95% bed occupancy.

The service had low out-of-area placements. Between 1 June 2021 – 31 May 2022 the service had seven out of area placements, two of these related to service capacity issues.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed. Between 1 July 2021 – 30 June 2022 the service had 12 delayed discharges which meant patients had to stay in hospital when they were well enough to leave. Most delayed discharges were due to no suitable accommodation being available in the community.

Staff did not always plan patients' discharge well, we reviewed 13 care records and found evidence of discharge planning in two care records. Aside from discussing placement options and providing information regarding medication, it was not clear from reviewing records or speaking to staff how the service worked with care managers to make sure discharge went well, or how staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality, however hot drinks and snacks were sometimes limited on the wards.

Each patient had their own bedroom, which they could personalise. However, access to some patients' bedrooms was being restricted across four wards based on their behaviour. This was not care planned for or reviewed by the service.

Our findings

Patients had a secure place to store personal possessions.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. However, on Brambling ward the door to the quiet area did not contain windows for observation, meaning service users could not access the areas without staff.

The patients had access to football courts, outdoor exercise equipment and a gym. There was a woodwork workshop available to patients and the service was trying to recruit a joiner in order to assist patients and develop their skills in this area. A range of activities such as; arts and crafts, cooking, photography groups and music sessions were delivered by the recovery and outcomes team at the activity centre. Patients being able to go to the activity centre was dependant on their level of authorised leave and staffing levels, meaning not all patients could attend.

Activities on the wards were based on staffing levels and could often be cancelled. All wards had activity timetables in place Monday – Friday. Activities on a weekend were not planned and happened on an ad-hoc basis. Activity timetables were sparse and the activity schedule on Fern ward was out of date and referred to patient appointments and sessions taking place the week before. Patients told us that they had to attend a daily early morning meeting in order to book leave in or retrieve personal items from secure storage, if they did not attend the meeting, they missed the opportunity. Patients said this restricts them if they have overslept or wanted to lie in.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private.

The service had an outside space that patients could access. However incident data showed that access to the courtyard on Swift ward was sometimes restricted for all patients, based on one patient's behaviour.

Patients could not always make their own drinks and snacks and were sometimes dependent on staff. On Fern ward, snacks or drinks were not freely available to patients and patients had to ask staff to make them a drink. A patient on Kestrel/ Kite ward told us they could not get a drink when they want because of staffing. Incident data also showed that patients on Clover/Ivy ward had to request a drink from staff, and access to drinks were suspended for all patients due to one patient's behaviour on both Brambling and Swift wards.

The service offered a variety of good quality food. Additionally, the service had organised traders to come to the hospital to provide more variety in the food available to patients on-site. The service had recently organised a series of coffee morning with fresh bakery products available and a fish and chip stall.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. There were education facilities on site to support patients in completing National Vocational Qualifications. One patient told us they were completing a business administration course and staff were supporting them to secure voluntary work. Staff told us they supported patients to attend college.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Our findings

Meeting the needs of all people who use the service

The service did not meet the needs of all patients. Staff could not always support patients with communication difficulties appropriately. Staff helped patients with advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people. All wards had rooms available for disabled patients and access to other equipment to assist with mobility, such as walking aids and shower chairs. Staff could not always meet the specific communication needs of patients within the service. Staff on the mental health wards were deployed to work on the learning disability and autism wards despite not all having been trained in the appropriate communication skills required for the patient group.

Staff did not make sure that all patients could access information on treatment, local services or their rights. On Fern ward there was no information leaflets available to patients on the ward. On Clover/Ivy ward information for patients was stored in a folder instead of being displayed on the ward. None of the wards we visited had patient information available in an easy read format. One patient told us they knew the information was available, but they were unable to read it.

The service could produce information leaflets in languages spoken by the patients and local community, if required.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff could block book interpreters to ensure that patients were supported where English was not their first language.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. There was a prayer room and chapel available to patients on site.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns.

The service displayed or gave patients information about how to raise a concern.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Between 1 July 2021 – 30 June 2022 the service received 25 complaints, of which three were partially upheld. None of the complaints were referred to the ombudsman. Themes from complaints included treatment and care, medication, staff attitude, continuity of care and safety and security.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers did not always share feedback from complaints with staff. One of the mechanisms for sharing feedback was through team meetings and all wards were not holding regular team meetings.

Our findings

The service used compliments to learn and celebrate success. We saw thank you cards and celebration posters on some wards. Swift ward had a display which showed positive messages from patients detailing how the service had helped them.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They did not have a full understanding of the services they managed. They were visible in the service and approachable for patients and staff.

Leaders within the service had the skills, knowledge and experience to perform their roles, however, they did not have a thorough understanding of the services they managed and the concerns we identified. They had not taken all appropriate action to address concerns raised during our previous inspection or drive improvement.

Senior managers had taken action to understand the services staffing shortages and provide a mechanism for staff to escalate staffing concerns. Oversight of daily staffing levels had improved since our previous inspection. Managers recognised that there were still system improvements to be made in relation to monitoring and reporting staffing and had plans in place to address these. However, they had not identified any robust plans to ensure consistency of familiar staff across the wards or taken action to allow staff to take breaks off the ward and reduce burn out in staff.

Leaders were unaware of the concerns we identified regarding the services safeguarding processes, however they had introduced a service dedicated safeguarding lead and were responsive when concerns were escalated to them.

They were unaware of the concerns we identified regarding incident reporting. There were no audits in place to ensure that incident recording was monitored effectively, in order to identify and address recording errors. When we raised incident reporting as a concern with the service leaders, they were unable to provide an effective response to the concerns.

Leaders were visible in the service and approachable to staff. Staff were able to give us examples of how they were personally supported by management and as a result felt more valued and satisfied in their role.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The provider was going through a 'journey to change' and was working directly with staff within the service to share and implement the new strategy. They were holding away days for staff and regular coffee mornings to encourage change within the service.

The trusts values were;

- Respect – listening, inclusive, working in partnership

Our findings

- Compassion – kind, supporting, recognising and celebrating
- Responsibility – honest, learning, ambitious

Staff were aware of the trust's values and mostly applied them to their work. Staff were aware of the 'journey to change' and felt involved in the process.

Culture

Most staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

The service carried out a staff survey between January – March 2022, the survey asked staff about the care they provide, if they can make improvements within the service, opportunities at work and how they felt about going to work. The satisfaction results from the survey had declined compared to the previous survey. The response to answers ranged from fair to very poor. The highest satisfaction score was that care being provided is a top priority for the team which was 66%. The lowest satisfaction rate was only 31% of staff stating that they looked forward to going to work.

Most staff we spoke to felt respected, supported, valued and proud to work for the service. We spoke to 25 staff regarding culture within the service and 20 of them felt that the culture had improved. All the staff we spoke to felt they were able to raise concerns without fear and they all told us that leaders took action to respond to their concerns promptly. Five staff told us they did not feel valued.

Ten of the staff we spoke to told us that morale was low across the service due to staffing levels and pressure.

Staff were able to give us examples of leaders directly supporting them with development. One staff member told us that when they were not successful in securing a new role within the service a senior manager had supported them in gaining experience to work towards the role in the future.

Most of the staff we spoke to knew who the Freedom to Speak up guardian was within the trust and knew how to access the trusts whistleblowing policy.

The service had initiatives in place to support staff with their wellbeing through an occupational health service, access to psychology and an employee assistance programme.

Staff within the service celebrated success. Managers complimented staff and provided encouragement and feedback about work they had completed well. We saw a board on Mandarin ward with positive and encouraging comments from managers.

Governance

Our findings from the other key questions demonstrated that governance processes operated ineffectively at team level and that performance and risk were not managed well.

There were ineffective governance process and systems within the service

Oversight of safeguarding processes had not been addressed by managers within the service, meaning managers could not be assured that patients were not exposed to or at risk of harm. Safeguarding referrals had not been made in relation to sexual safety incidents and incidents of violence and aggression.

Our findings

Governance processes failed to identify that staff did not always report incidents when needed, or that incidents were being grouped together and categorised incorrectly. Incident reports related to sexual safety and physical abuse had not been submitted by staff. The trust had a centralised approvals process in place for reviewing all incidents across the trust, however the service had plans in place to bring the responsibility of reviewing incidents back into the service to provide more thorough oversight.

Managers were unaware of the threating language being used towards a patient regarding their section 17 leave and were unaware of restricted access to patients' bedrooms across four wards, meaning these issues had not been raised and addressed.

Managers were aware of the concerns regarding unfamiliar staff working on wards, however there were no plans in place to ensure continuity of care and consistency of staff within wards. Managers within the service deployed staff from mental health wards to work on the learning disability and autism wards, and some staff did not have the necessary communication skills and knowledge to meet the needs of the patient group.

Managers had failed to ensure that environmental risks on Sandpiper ward had been addressed to prevent further patient safety incidents.

There were no systems or management oversight in place to ensure that team meetings were regularly taking place on the wards. Nine out of 14 wards did not have regular team meetings. This meant that staff did not always receive feedback following the investigation of incidents or complaints in order to improve quality and safe practice within the service.

Audits within the service were not always effective in identifying issues on the wards. The handover documentation for patients did not contain, or lacked detail regarding patient risk on Nightingale, Mallard and Mandarin wards. In addition, where patients were on enhanced observations documentation was not dated and information regarding their associated risks for enhanced observation was not included.

Staff reported that the care records system could be very slow, sometimes froze and power cuts within the service resulted in information being lost and having to be input again. These issues had been identified over 12 months ago and managers had not addressed these issues During our inspection, staff found it difficult to find specific documentation in the care records system such as mental capacity assessments and detention papers.

Management of risk, issues and performance

Teams did not always have easy access to the information they needed to provide safe and effective care.

The service had business continuity plans for emergencies such as adverse weather or a flu outbreak.

The service was operating in business continuity measures during our inspection and had been for 12 months prior to our visit. The service did not have a robust recovery plan in place to outline what they needed to achieve to stop operating in business continuity or timelines for this to be achieved.

The service had monthly ward improvement group meetings (WIG) in place which should take place monthly on every ward. The information was then fed up to a monthly quality assurance group (QuAG) meeting attended by modern matrons and senior managers within the service. However, WIG meetings were not taking place regularly across most wards. In the QuAG meeting in May 2022 it was reported that in a 12-month period prior, no WIG meetings had taken place on Brambling ward. The average number of meetings taking place across the service was five in 12 months.

Our findings

Ward managers did not have ward level risk registers in place and were unaware of what was on the service level risk register. Qualified staff we spoke to were unaware of what the risk register was or how they would escalate concerns on to the risk register.

Leaders discussed a service level risk register at their monthly QuAG meeting. However; following our previous inspection in June 2021 we identified significant issues relating to safeguarding and raised concerns regarding team meetings not taking place, quality of incident reporting and staff not being able to take breaks. These items were not added to the service risk register until April 2022 and had not been graded by severity to display how low or high risk each item was. We identified issues in these areas again during our visit, with little or no action taken to address the associated risks.

We identified issues with staff being able to easily access and locate important information. Templates within the care records system could only be saved as 'blank letter template' due to naming restrictions within the system. During our inspection, staff members found difficulty navigating the system and the electrical issues on Fern ward identified in our June 2021 inspection had not been addressed.

Information management

Staff collected and analysed data about outcomes and performance.

Staff did not always make notifications to external bodies when required. For example, safeguarding referrals had not been made for instances of violence and aggression and sexual safety.

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work, but the care records system were slow, and some information was difficult to find.

Information technology infrastructure, including the telephone system, worked well in the main and helped to improve the quality of care. However, we found mobile phone network and Wi-Fi connection was problematic on the site.

Ward managers had access to information in an accessible format to support them with their management role. This included information on the performance of the service, staffing and patient care.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff, patients and carers had access to up-to date information about the work of the provider and the services they used. This was through the intranet, communications to staff and newsletters. Carers had access to online and face to face meetings. Away days were held for staff and the views of staff were being sought as part of the trust's 'journey to change'.

Patients and carers had opportunities to give feedback on the service they received through surveys and the providers complaints process.

Our findings

Patients were involved in decisions made about the service to encourage improvement. The service had produced a training film for staff which was co-produced with service users to portray the challenges that patients face during their stay in a forensic hospital setting.

Learning, continuous improvement and innovation

The service participated in the Royal College of Psychiatrists Quality Network for Forensic Mental Health Services. The network meetings discussed what was working well within the service and what the areas for improvement were.

Staff in the service were unable to tell us about any research or accreditation schemes they were taking part in.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action the trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that all patients are safeguarded from abuse; all patients are treated with kindness and respect and that safeguarding referrals are sent to the local authority when appropriate to do so, and action taken to safeguard patients is documented in line with the safeguarding adults policy. (Regulation 13)
- The trust must ensure any restrictions placed on patients are individualised, proportionate, regularly reviewed and removed as soon as possible. (Regulation 13)
- The trust must ensure that all staff receive and are compliant with a mandatory training programme which meets the needs of all patients within the service and that staff have completed appropriate training to meet the needs of people with a learning disability and autistic people. (Regulation 18)
- The trust must ensure that the wards within the service are staffed in accordance with its assessed safe staffing numbers so that care and treatment is delivered in a safe way; patients have access to activities, psychological interventions, occupational therapy, escorted Section 17 leave and staff can take their breaks. (Regulation 18)
- The trust must ensure that patients have comprehensive discharge plans in place, which are developed from the point of admission. (Regulation 9)
- The trust must ensure that staff update all ward noticeboards so that patients and staff have easy access to the most up to date information about the ward and wider service, including access to easy read information. (Regulation 9)
- The trust must ensure that all ward environments are clean, well maintained and fit for purpose and that the generator testing issues on Fern ward are rectified. (Regulation 15).
- The trust must ensure that all incidents within the service have been reported by staff using the trust's incident reporting procedure and that there are systems in place to monitor this. (Regulation 17)
- The trust must ensure that seclusion reviews are carried out as outlined in the MHA code of practice and ensure that seclusion rooms contain a two-way intercom that is fit for purpose and a clock. (Regulation 12)
- The trust must ensure that patients health is appropriately monitored, including HDAT, blood glucose and where appropriate bowel monitoring. (Regulation 12)
- The trust must ensure that regular team meetings take place on all the wards within the service to ensure staff can escalate and receive key information on the service. (Regulation 17)
- The trust must ensure that information and documentation within its care records system is easily accessible for all staff within the service and that systems used to document patient information are in full working order. (Regulation 17)

Action the trust SHOULD take to improve:

- The trust should ensure that all staff receive regular managerial and clinical supervision.

Our findings

- The trust should ensure that action has been taken to make all ward environments as low risk as possible.
- The trust should ensure that all oxygen cylinders are stored securely.
- The trust should ensure that care records are developed and documented to include the patient voice.
- The trust should ensure that patient capacity to consent is assessed and recorded clearly.
- The trust should ensure that patients can freely access drinks and snacks on the ward.

Our inspection team

Our inspection team comprised one lead inspector, two team inspectors, two medicines inspectors and one Mental Health Act reviewer. The team also had a specialist advisor who was a registered nurse and an expert by experience.

On this inspection, we assessed whether the service had made improvements in response to the concerns we identified during our last inspection.

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

During the inspection visit, the inspection team:

- visited 14 wards;
- looked at the quality and safety of each ward environment;
- spoke with 34 patients and their families;
- spoke to 76 members of staff including ward managers, a consultant psychiatrist, nurse consultants, qualified nurses, health care assistants, a clinical psychologist; an occupational therapist, activities co-ordinators and a pharmacist technician;
- attended five multi-disciplinary report out handover meetings;
- reviewed 13 patient care and treatment records;
- observed care on the wards; and
- looked at a range of audits, policies, procedures and other documents relating to the running of the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing