Avesbury House

Quality Report

85 Tanners End Lane
London
N18 1PQ
Tel: 020 8803 7316
Website: www.partnershipsincare.co.uk

Date of inspection visit: 18 - 19 August 2015
Date of publication: 24/02/2016

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Avesbury House as **requires improvement** because:

- The provider did not have an up-to-date ligature risk assessment.
- All staff did not have access to a personal alarm.
- There were some staffing shortages on the weekends.
- The provider had not submitted all required statutory notifications to the CQC.
- There were no systems in place to identify, receive, record, handle, respond to and learn from complaints. All complaints were resolved informally and not centrally recorded. The provider had no record of any formal complaints made in the past year. Some patients wanted to make a complaint, but did not know how or did not feel comfortable to make a complaint.
- The provider had not put systems in place to ensure records were complete, accurate and up-to-date, including patients' care records, staffing rotas, staff supervision, staff training and community meeting minutes.
- Patients' care records were stored on two separate electronic systems in addition to the paper files. This was time consuming for staff and duplicated work. Staff did not always transfer information between the various systems. Risk assessments were not available for all patients on the electronic system that nurses accessed.
- Staffing numbers were recorded on the staffing rota, daily planning rotas and staff time sheets. The daily planning rotas did not account for any absences such as sick leave. It was unclear from these records what the staffing numbers were on any given day.
- Not all staff received regular monthly supervision. Records of staff supervision and training were not accurate.
- A community meeting took place every fortnight where patients could express their views on the daily routines of the ward. Patients whose first language was not English said they were not involved with these meetings. Issues recorded in the meeting minutes were often carried over with no recorded outcome or person responsible for addressing that action.
- There was no formal service level agreement in place between Care UK and BEH trust regarding joint policies and clinical governance.

However:

- Patients said they felt safe at Avesbury house.
- There was good multidisciplinary input.
- Care records were of a good standard.
- Patients said staff were caring and treated them with respect.
- Staff had a good understanding of individual patient's histories and care needs and patients said they felt involved in decisions about their care and treatment.

Summary of findings

Contents

Requires improvement

Avesbury House

Services we looked at

Forensic inpatient/secure wards

Summary of this inspection

Background to Avesbury House

Avesbury House is provided by Partnerships in Care 1 Ltd.

The service provides a 24-hour low-secure service to male patients with severe and enduring mental health needs, often with forensic history. It has 25 beds across five independent living units.

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

NHS England contracted 24 of the beds at Avesbury House. NHS England commissioned the North London Forensic Service at Barnet, Enfield and Haringey Mental Health NHS Trust to provide the secure beds and forensic multidisciplinary team. The North London Forensic Service subcontracted Partnerships in Care 1 Ltd. to provide the Avesbury House building, nursing staff and support workers. This arrangement has been in place for the past 15 years.

We have inspected Avesbury House under their previous provider Care UK and this report was published in March 2014. At the last inspection, Avesbury House was meeting essential standards, now known as fundamental standards.

Avesbury House is registered for the following regulated activities:

Treatment of disease, disorder or injury

Assessment or medical treatment of persons detained under the Mental Health Act 1983

Registered Manager: Santos Traquino

Accountable Officer: Santos Traquino

Our inspection team

The team that inspected this service consisted of a consultant forensic psychiatrist, an expert by experience, a CQC inspection manager, three CQC inspectors, a Mental Health Act reviewer, a mental health nurse and a pharmacist inspector.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the service and asked other organisations for information.

During the inspection visit, the inspection team:

Summary of this inspection

- Toured the hospital and looked at the quality of the environment.
- Spoke with 16 patients.
- Spoke with the hospital manager who was also the registered manager of the service.
- Spoke with 19 staff members, including senior managers, doctors, domestic staff, maintenance staff, nurses, an occupational therapist, a pharmacist, a clinical psychologist, social workers and support workers.
- Looked at 12 patient care and treatment records.
- Observed how staff cared for patients.
- Carried out a specific check of medication management in the service.
- Carried out a Mental Health Act monitoring visit.

Looked at a range of records, policies and documents relating to the running of the service.

What people who use the service say

We spoke with 16 patients, including five whom we spoke with using interpreters, as English was not their first language. The majority of patients said they felt safe at Avesbury House, were involved with their care and had received copies of their care plan. They said staff were caring and treated them with respect. Patients were positive about the activities available, the focus on rehabilitation into the community and the support staff gave them to live independently. Patients said staff sometimes cancelled their leave, but it would usually reschedule it for another time. Some patients told us they did not know how to make a complaint.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- The provider did not have an up-to-date ligature risk assessment.
- Not all staff had access to a personal alarm.
- There were some staffing shortages on the weekends.
- The provider had not submitted all required statutory notifications to the CQC.

However:

- The environment was generally clean and tidy.
- Patients said they felt safe at the hospital.
- The multidisciplinary team ensured there was clear joined-up management of the referral and treatment pathway and had a good understanding of patients' risks.
- The service did not use seclusion, restraint or rapid tranquilisation.
- There were appropriate arrangements in place for medication management.

Are services effective?

Good

We rated effective as **good** because:

- All care records were of a good standard.
- Staff completed physical health assessments on admission and on-going monitoring was evident.
- There was good joint working and communication between the nursing team, medical team, therapists and social workers.
- Staff had a good understanding of the Mental Health Act and Code of Practice.
- Most staff could explain the principles of the Mental Capacity Act and had completed training.

Are services caring?

Good

We rated caring as **good** because:

- We saw kind and caring interactions between staff and patients.
- Patients said staff were caring and treated them with respect.
- Staff had a good understanding of individual patient's histories and care needs.
- Staff wrote patients' comments in the first person in their care plans. Patients signed their care plan and staff gave them a copy.

Summary of this inspection

- Patients said they felt involved in decisions about their care and treatment.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- There were no systems in place to ensure a system to identify, receive, record, handle, respond to and learn from complaints. All complaints were resolved informally and not centrally located. The provider had no record of any formal complaints made in the past year. Some patients wanted to make a complaint but did not know how to or would not feel comfortable to make a complaint.

However:

- There was a good range of activities available and patients spoke positively about the service being recovery focussed.
- The service actively worked to support patients whose first language was not English.

Are services well-led?

Requires improvement

We rated well led as **requires improvement** because:

- There were no systems in place to ensure records are complete, accurate and up-to-date including patients' care records, staffing rotas, staff supervision, staff training, and community meeting minutes.
- There was mixed staff morale on the ward. Some staff said they would not feel confident raising concerns and were fearful of victimisation.
- Some staff did not feel management were properly addressing issues that they raised.
- There was no formal service level agreement between Care UK and BEH trust regarding joint policies and clinical governance.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Seventy-seven percent of staff had completed training on the MHA. Most staff we spoke with had a good understanding of the MHA and Code of Practice and could explain how they used it in practice.
- The use of the MHA was good. Staff completed MHA documentation correctly, up to date and stored records appropriately.
- The hospital employed a MHA administrator on site four days a week with additional support provided from the regional MHA officer.
- Patients had access to an Independent Mental Health Advocate who attended the hospital for eight hours every week. Not all patients were aware of this service.
- The consultant psychiatrist completed consent to treatment forms on admission. For example, there was no evidence of an assessment of staff completing capacity and consent on T2 certificates of consent to treatment for two patients. On one record, we found that staff requested for a second opinion appointed doctor for a patient who had previously been receiving treatment authorised by a T2 certificate. It was unclear whether this was because the patient no longer had capacity or had withdrawn their consent. Further, treatment had continued for three weeks without a clear statement on the record that it was considered immediately necessary to do so. We raised this with the provider at the time of our inspection who took action following the inspection.
- Staff gave patients information about the MHA on admission to the hospital and repeated on a regular basis at least once every three months. Patients we spoke to understood how the MHA applied to them.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Eighty-three percent of staff had completed Mental Capacity Act (MCA) training.
- Most staff were able to explain the key principles of the MCA. Staff said the consultant made decisions regarding a patient's capacity and assessed capacity during ward rounds, MDT meetings and individual assessments in conjunction with and individually with other disciplines and individually. Staff were able to seek advice and support about decisions relating to the MCA from the social workers based in the service.
- There were no patients subject to deprivation of liberty safeguards at the time of our inspection.

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- In early 2014, Avesbury House changed its environment to meet NHS England's low-secure unit specifications. This meant they had extended the outer wall height, installed an air lock and created a role of security staff on each shift.
- There were blind spots throughout the independent living units where staff could not always view patients from communal areas. Each shift had an allocated security support worker allocated to security that completed hourly checks on patients and the environment. The provider also mitigated risks by referring and admitting patients suitable for the environment at Avesbury House. The North London Forensic Service at Barnet, Enfield and Haringey Mental Health NHS Trust has provided the forensic multidisciplinary team (MDT) for Avesbury House for the past 15 years. This meant that the clinicians managed all referrals from the North London Forensic Service to Avesbury House. The clinicians assessed appropriate patients at North London Forensic Service with good knowledge of their past and present risk histories.
- There were ligature points in each room, including door handles and taps in the bathrooms. The ligature assessment was not available at the time of our visit and some staff were not aware of ligature risk assessments. We requested the ligature assessment but the provider could not locate this following the recent change in provider. Staff said there were no patients at the time of our visit who were at risk of self-harm via ligatures. Staff considered ligature risks when assessing patients for admission. Patients at risk of self harm would have increased observation levels and staff would develop a contingency plan to consider if they needed to transfer the patient to a more appropriate environment. The provider had no incidents involving ligatures in the past 12 months.
- The clinic room was clean and tidy. Staff completed regular checks of the emergency equipment. There was no examination couch available. However, staff completed physical examinations that required patients to lie down in their side rooms. Equipment that was necessary to monitor physical health was available.
- The hospital was clean and tidy. The provider had recently redecorated the flats and the management team informed us they had ordered new furnishings for the hospital that were due to arrive the week following our visit.
- The provider had hand washing facilities available throughout the hospital.
- There were nurse call points throughout the hospital and staff carried personal alarms. However, staff said there were not always enough personal alarms each shift. Staff had reported this as an incident twice in June.
- Security staff held the keys for ward staff and provided them to staff members when they arrived for their shift. Staff attached their keys to a belt and did not take these off the premises. Staff carried a mobile phone when escorting patients off the premises so they could contact their team for more support when required.
- Patients said they felt safe in the hospital and most felt the hospital environment was generally clean. The maintenance team repaired any issues in a timely manner.

Requires improvement

Forensic inpatient/secure wards

Safe staffing

- The ward established minimum safe staffing level was two qualified nurses and seven support workers during the day, and two qualified nurses and two support workers at night. There was a qualified nurse on each shift.
- There were five support worker vacancies at the time of our inspection. The manager said they were actively recruiting for these positions.
- The service used bank staff who regularly worked at the hospital and rarely used agency staff.
- The manager could adjust staffing levels based on need, for example if a patient required increased levels of observations.
- Staffing numbers were recorded on the staffing rota, daily planning handover and staff time sheets. However, it was unclear from these numerous records what the staffing numbers were on any given day. For example, daily planning handovers for 7 to 9 August 2015 stated that there were eight members of staff on shift, when there is a daily establishment of nine per shift. The daily planning handover did not indicate why the ward was one member of staff short. Following our visit, the hospital manager clarified that staff had worked over time, which was recorded separately in the ward diary. This meant that the systems in place to record staffing numbers were not always accurate.
- Staff said there were sometimes staffing shortages on the weekends. Staffing records we requested for June and July 2015 indicated that staffing did not meet the required establishment over the weekends. During these two months, six shifts were short by one or two members of staff during the weekend.
- Staff and patients said sometimes patients' leave had to be cancelled or rescheduled due to staff shortages. Staff had not cancelled any activities.
- There was full-time medical coverage of a consultant and doctor on site Monday to Friday. An on-call consultant was available at Chase Farm Hospital for out of hours and weekends.

Assessing and managing risk to patients and staff

- Avesbury House had access to a forensic MDT including medical staff, a clinical psychologist, occupational therapists and social workers. The forensic MDT at the North London Forensic Service at Barnet, Enfield and Haringey Mental Health NHS Trust has provided the MDT team for Avesbury House for the past 15 years. This meant that there was clear joined-up management of the referral and treatment pathway and the forensic MDT had a good understanding of patients' risks. Patient referrals came from the North London Forensic Service medium and low-secure environments. Additionally, they also had referrals for catchment area patients from independent sector placements that the North London Forensic Service held responsibility for their aftercare. Nurses completed a formal assessment to determine the suitability of patient referrals. The forensic MDT also assessed for appropriate referrals to the service and patients would receive continued treatment from the team. If patients required a more secure environment, staff could transfer them back to North London Forensic Service.
- Most patients had an up-to-date historical clinical risk management-20 (HCR-20) risk assessment completed, which is a specific risk assessment for people with forensic histories. Staff reviewed risks during a patient's care programme approach (CPA) meeting and included evidence of the forensic MDT discussions to inform the assessment. Staff uploaded reports onto the electronic system and a member of the forensic MDT was responsible for printing this off and placing it in the patient's files for nursing access. However, six out of 24 patients did not have a HCR-20 in their paper files. This meant that staff could not always access updates to patients' risk assessments due to staff using multiple records systems. Staff printed off four of the missing risk assessments during our visit and the other two were under review.
- Staff did not use restraint, rapid tranquilisation or seclusion with patients. Staff used de-escalation techniques and had completed training for this. Staff felt safe at work and confident to manage aggression.
- Staff discussed relational security issues and knew how to keep themselves safe in the hospital.
- Staff completed a risk assessment every time a patient went on leave to assess the risks the patient may encounter while on leave.
- Staff conducted targeted and random searches of patients and bedrooms. Staff searched five bedrooms each week. They searched patients for items on the 'contraband' list when they returned from unescorted

leave using a pat search and metal detector. There was a designated room for this and a male member of staff conducted searches with another member of staff present.

- Staff made safeguarding referrals to the social work manager for North London Forensic Service who the local authority employed. Staff could contact the social work manager and discuss whether it was a safeguarding alert. However, staff did not submit statutory safeguarding notifications to the CQC as required. The provider had identified staff were not submitting notifications prior to the inspection in July 2015 and assured us that this would be completed going forward.
- Appropriate arrangements were in place for obtaining medicines. Staff told us how they obtained medicines and supplies were available to enable patients to have their medicines when they needed them. We checked the medicines for each of the 24 patients and saw no medicines were out of stock.
- Medication was stored securely. Medicines requiring cool storage where stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. Staff administered medication through a stable door. Staff kept generic medication in alphabetical order. The medication trolley stored current medication in alphabetical order. The controlled drugs cupboard was clean and tidy and staff recorded checks at the start of each shift. The recording book was legible and staff checked administration records each shift and cross-referenced to prescription charts. Staff completed the fridge temperature check book with no omissions.
- Appropriate arrangements were in place for recording the administration of medicines. These 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.
- Where medicines were prescribed to be given 'only when needed' or where they were to be used only under specific circumstances, individual protocols were in place. They provided information to enable nursing staff to make decisions as to when to give these medicines to ensure people were given their medicines when they need them and in way that was both safe and consistent.
- Patients were able to self-administer their own medicines after staff completed a detailed assessment and they were assessed as suitable. At the time of our visit, three patients were looking after and taking their own medicines.
- The provider had weekly visits from a pharmacist who checked staff gave medicines safely to patients and the administration of medicines recorded correctly. Records showed staff highlighted any concerns and action taken. This meant the provider had systems in place to monitor the quality of medicines management.

Track record on safety

- The service had no serious incidents reported in the last 12 months.

Reporting incidents and learning from when things go wrong

- Staff could describe the reporting process and what constituted an incident.
- The manager did not have access to the incident reporting system. The regional manager emailed the hospital manager information about incidents staff reported and received an automatic email from the reporting system. This meant that management did not have local oversight and ability to manage and close incidents when reported by staff.
- The provider had no formal system to document incident outcomes and trends. The manager was working on implementing an outcomes folder to disseminate information to staff during team meetings.
- Between January and August 2015, staff reported 17 medication error incidents. Seven of these were discovered as a result of a pharmacy audit. The CQC had received an anonymous complaint about the service in April 2015, which the provider investigated and provided an action plan. One of the concerns was around medication errors. As an action point, staff completed medication management training in May. However, 13 of the medication errors occurred after staff completed the training.
- One member of staff described an incident where they did not receive any feedback or debrief.

Are forensic inpatient/secure wards effective?

Requires improvement

Forensic inpatient/secure wards

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- North London Forensic Service referred all patients to Avesbury House. Prior to admission, staff went to North London Forensic Service and completed an assessment with the patient. The staff at Avesbury House discussed the patient's needs and how they could manage these within the environment. Patients could visit Avesbury House prior to admission.
- Patients' care records were stored on two separate electronic database systems, one for Avesbury House nursing staff and one for the trust's staff. Patients also had paper files. This meant that it was time consuming for staff to copy information over from one database involving duplication of work. In some instances, information was not always up to date and nursing staff did not have access to the trust staff's electronic records. The management team were aware of this issue.
- Staff said they were assigned to one flat each day and wrote up daily notes about the five patients who lived in the flat. However, another member of staff may have worked with one of the patients during the day and staff would not record this information. This meant here was a risk that patient's daily case notes were not always accurate or complete.
- Most care records were of a good standard. Admission documentation was complete and recorded on patients' paper file and electronic record. Staff completed physical health assessments on admission and on-going monitoring was evident along with blood results, hospital letters, and examination forms. Specific physical health concerns were included in care plans, reviewed monthly and staff recorded on-going monitoring.
- Staff completed care plans following review meetings and included needs expressed in the meetings and historical clinical risk management-20 (HCR20) update. Staff completed nursing care plans following the initial 72-hour care plan on admission and reviewed them monthly.
- Section 17 leave arrangements were included in care plans and the escorting member of staff updated notes to care plans following each leave.
- Progress notes were concise, informative and included information about physical health. Staff documented any medication reviews or refusals in the patient's progress notes.

Best practice in treatment and care

- The pharmacist conducted audits on clozapine, high doses and medication expiry dates.
- Staff completed health of the nation outcome scales for patients.
- Staff recognised data collection and involvement in audits as areas for improvement.
- A psychologist assessed patients within four weeks of admission, reviewed their therapeutic needs, and completed an intervention plan. Patients could access individual and group psychology sessions including drug and alcohol or reasoning and rehabilitation.

Skilled staff to deliver care

- In three of the months between January 2015 and August 2015, less than half of the staff received supervision. The monitoring of monthly supervision was recorded on paper and then saved electronically. However, the paper records did not match the electronic records. New staff were positive about the induction they completed. They were provided with information about patients and shadowed another member of staff for a week. Staff were given copies of security policies and information about the low secure environment.
- All staff had appraisals updated in July 2015.
- Staff could access mandatory training courses but did not have access to more specialist training. Staff training records were completed monthly up to June 2014 and then not until July 2015. Training records for bank staff were also not up to date. It was unclear when staff were due for training and that the numbers of compliant staff was incorrect. Staff who were booked on for training in September was not recorded on the spreadsheet.
- Files for recently recruited staff had the appropriate documentation including references, disclosure and barring service check and copies of identification.

Multidisciplinary and inter-agency team work

- Staff said that the teams worked together well and there was good communication between the nursing team

and the medical, therapy and social work staff. Nursing staff said the medical staff and allied health professionals were accessible and could be contacted when they were not on the unit.
- Staff were required to attend the daily handover and said they felt their opinions were valued and could contribute to these meetings.
- Barnet, Enfield and Haringey NHS Mental Health trust had regular contact meetings with Avesbury House. This involved information management and targets set by commissioners. There was also daily communication between the hospital manager and the wider MDT. There were monthly clinical governance meetings.
- Representatives from Care UK Mental Health Partnership Limited and BEHMH trust were on the interview panel to appoint the current manager.
- The service had bi-monthly team meetings and monthly meetings for nurses.
- The service had good links with the local GP who conducted patients' annual health checks.

Adherence to the MHA and the MHA Code of Practice

- Seventy-seven percent of staff had completed training on the Mental Health Act (MHA). Most staff we spoke with had a good understanding of the MHA and Code of Practice and could explain how they used it in practice. The use of the MHA was generally good. Staff completed MHA documentation correctly, up to date and stored records appropriately.
- The hospital employed a MHA administrator on site four days a week with additional support provided from the regional MHA officer.
- Patients had access to an Independent Mental Health Advocate (IMHA) who attended the hospital for eight hours every week. Not all patients were aware of this service.
- The consultant completed consent to treatment forms on admission. There was no evidence of an assessment of staff completing capacity and consent on T2 certificates for consent to treatment for two patients. On one record, we found that staff requested for a second opinion appointed doctor for a patient who had previously been receiving treatment authorised by a T2 certificate. It was unclear whether this was because the patient no longer had capacity or had withdrawn their consent. Further, treatment had continued for three weeks without a clear statement on the record that it was considered immediately necessary to do so. We raised this with the provider at the time of our inspection who took action following the inspection.
- Nurses read patients their rights every month and recorded evidence of this in patients' records.
- Staff gave patients information about the MHA on admission to the hospital and repeated on a regular basis at least once every three months. Patients we spoke to understood how the MHA applied to them.

Good practice in applying the MCA

- Eighty-three percent of staff had completed Mental Capacity Act (MCA) training.
- Most staff could explain the key principles of the MCA, although did not always put this into practice. Staff said the consultant made decisions regarding a patient's capacity and assessed capacity during ward rounds, MDT meetings and individual assessments in conjunction with and individually with other disciplines and individually. However, the most relevant person should assess capacity and on a decision basis so this reflected a lack of understanding of the MCA.
- There were no patients subject to deprivation of liberty safeguards at the time of our inspection.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- We saw kind and caring interactions between staff and patients.
- Patients said staff were caring and treated them with respect.
- Staff had a good understanding of individual patient's histories and care needs.
- Some patients said that staff did not always knock before entering their bedroom.

The involvement of people in the care they receive

- Patients received a handbook and an orientation to the hospital environment as part of the admission process and were given the opportunity to visit the ward.

Requires improvement

Forensic inpatient/secure wards

- Patient received a copy of the section 17 leave document if changes were made.
- Patients received leaflets pertaining to their rights as detained patients.
- Patients said they received information about their medication.
- Staff recorded patients' comments in the first person in their care plans indicating that they had been involved. Patients signed their care plan and staff gave them a copy. If a patient did not accept their care plan, staff recorded this in their records. The patient's named nurse discussed the content of their care plans with them monthly.
- Patients said they felt involved in decisions about their care and treatment. Discussions took place at ward rounds that patients attended. They felt staff listened to them.
- Patients spoke positively about their leave from the ward, which they used to engage in community activities and supported their integration into the community. One patient went to the local library, coffee shops, a weekly IT course and church every Sunday. Other patients told us about visits to local towns such as Enfield, Edmonton and Barnet. Patients told us that they cooked their own meals between once and five times each week and they used their leave to go shopping for food. Other activities included going to the local gym and a 'Mind' day centre.
- A community meeting took place every two weeks where patients could express their views on the daily routines of the ward. Patients whose first language was not English said they were not involved with these meetings due to language barriers. Issues recorded in the minutes of the meetings were often carried over with no recorded outcome or person responsible for addressing that action. For example, it was noted in the meeting on 19 May 2015 that a flat needed cutlery. This was repeated in the minutes of the subsequent four meetings up to 11 August 2015 where it stated that this had been ordered. A patient requested a can opener for one of the flats on 14 July 2015 and remained on the minutes for 11 August 2015 with no outcome recorded.
- Some patients said the service did not have opportunities to provide feedback about the service or be involved in decisions about the service.

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

(for example, to feedback?)

Requires improvement

Access and discharge

- Some patients had been at Avesbury House for several years. The hospital manager said that five patients were actively ready for discharge but these were delayed due to external factors. A few patients were on the pathway towards discharge. One patient who had been at Avesbury House for over five years said that there had been no discussion about their move on and although they wanted to be discharged, they were not aware of their discharge plan.
- When Avesbury House changed from a step-down service to a low secure, patients had not had a gatekeeping assessment to determine whether they met the criteria of a low secure unit.
- The average length of stay varied for patients from months to several years. One patient had been at the service for over four years. The most recent admission was in December 2014.
- NHS England commissioned the beds at Avesbury House, which Hospital at Barnet, Enfield and Haringey Mental Health NHS Trust block purchased.

The facilities promote recovery, comfort, dignity and confidentiality

- Each flat had its own kitchen, a communal dining space and living room.
- The hospital had a large communal dining area and lounge and patients had unrestricted access to an enclosed garden.
- There was a multi-faith room in one of the flats with information about different religions.
- Patients could access their rooms throughout the day. They had fob keys for their flat and individual room keys to lock their doors. There was also a locked cupboard in their rooms.
- All but five bedrooms on the ground floor had en-suite toilet and shower facilities.
- Patients did not have access to mobile phones in the hospital. This was a blanket restriction that was not

Requires improvement

Forensic inpatient/secure wards

based on individual risk. They could access their mobile phone when they went out on leave. There were payphones on the corridors of each flat. The hospital had a resource room where patients could access a computer without internet access and make phone calls in private.

- There was a range of activities offered to patients, including some that were located in the community such as football, swimming and gym. Staff planned activities a week in advance and patients had individualised plans. Staff delivered a cinema club, art groups, played cards, bingo and games with patients in the lounge. The five patients whose first language was not English could access English classes. Patients also went on annual outings to the seaside.
- There was a visitor room and an annex for patients to visit with any children.
- Most patients said they liked the food and had access to hot drinks and snacks at any time through the day and night.
- Patients spoke positively about the service supporting their recovery, independence and involvement with activities in the community and getting back into work-related activities.

Meeting the needs of all the people who use the service

- Patients accessed spiritual support in the community. One patient had their time of medication changed during Ramadan because they were fasting.
- The service worked to meet the needs for patients whose first language was not English. These patients said they could access an interpreter. Interpreters attended for formal meetings including CPA and ward rounds. Films were shown with subtitles. One member of staff described how they provided a patient whose first language was not English a set of pictures showing various emotions so he could express how they were feeling to staff. Another patient received counselling and also joined a mental health group in their native language.
- The ground floor had disabled access and disabled toilet facilities.
- Vegetarian and halal food options were available.

Listening to and learning from complaints

- There was information displayed around the hospital about the complaints process flow chart. However, not all patients said they knew how to make a complaint. Some patients said they would not feel comfortable making a complaint. One patient said when they had made a complaint that the service always took the staff member's point of view.
- The service did not have any formal complaints recorded for the last 12 months. The manager said that complaints received were informal, resolved locally and recorded in patient's progress notes. Staff discussed informal complaints in the monthly clinical governance meetings and community meetings. However, this meant that the provider did not provide the process to appeal a complaint through the formal stages. Some staff said they were not clear on the process of how to manage a complaint of a concern.
- At the time of our inspection Partnerships in Care 1 Ltd. had a complaints policy dated June 2012, which they since updated in December 2015. This policy outlined recording complaints on an informal complaints resolution log and managed by a complaints officer, neither of which were in place at the time of our inspection.
- The CQC had received an anonymous complaint about the service in April 2015, which the provider investigated and provided an action plan. Some of the actions that the provider documented as completed remained outstanding including the recording of staff overtime and ensuring all patients knew how to make a complaint.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

- Partnerships in Care 1 Ltd. took over Avesbury House on 1 June 2015. Most staff felt that positive changes had been happening at the service because of the recent change of provider. However, staff said they had not yet received a full introduction to Partnerships in Care 1 Ltd. This meant that they did not have an awareness of the new organisation's vision and values. The provider had not yet changed over some of their policies and systems on account of our inspection.

Good governance

Requires improvement

Forensic inpatient/secure wards

- The provider had not ensured that effective systems were in place to ensure that all staff were regularly supervised, that there was sufficient staffing on weekends and complaints were dealt with appropriately.
- The provider had not ensured that effective systems were in place to ensure records were complete, accurate and up-to-date, including patients' care records, risk assessments, staffing rotas, staff supervision, training records and community meeting minutes.
- Most staff were up to date on mandatory training and appraisals.
- Partnerships in Care 1 Ltd. was the detaining authority for patients detained under the MHA.
- BEH Trust provided the medical, psychological, occupational therapy and social work services. These staff were subject to the employment and HR policies and procedures of the trust.
- Partnerships in Care 1 Ltd. provided the registered manager, nursing, catering, security, maintenance and housekeeping staff. These staff were subject to the employment conditions of Partnerships in Care 1 Ltd.
- Partnerships in Care 1 Ltd. and BEH trust held local governance meetings attended by senior clinicians and heads of departments. There was no formal service level agreement in place at the time of our inspection. The provider has since updated that they will be conducting a review of the clinical governance structure and are in the process of formalising a contract.

Leadership, morale and staff engagement

- There was a mix of staff morale. Some staff said they felt people did not work as a team and that some team members were supportive while others were not. One member of staff said they felt some staff did more than others.
- Some staff said they would not feel confident raising concerns and were fearful of victimisation. One member of staff said they experienced bullying but did not feel comfortable reporting it to management. Some staff did not feel management were properly addressing issues that they raised. There was no whistleblowing policy in place at the time of our inspection. Partnerships in Care 1 Ltd. have since implemented a whistleblowing policy for staff.
- Staff felt there were opportunities for professional development. Some support workers were in the process of completing their nursing qualification.
- There was a staff opinion box where staff could provide anonymous suggestions.

Commitment to quality improvement and innovation

- There was no commitment to quality improvement and innovation found during this inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that they submit all required statutory notifications to the CQC.

The provider must ensure that there is an up-to-date ligature assessment for each independent living area and that all staff are aware of ligature risks and how to manage them.

The provider must ensure that systems are in place to ensure records are complete, accurate and up-to-date, including patients' care records, risk assessments, staffing rotas, staff supervision, training records and community meeting minutes.

The provider must ensure that there is a system in place to identify, receive, record, handle, respond to and learn from complaints.

Action the provider SHOULD take to improve

The provider should ensure they mitigate blind spots on the wards.

The provider should ensure that all staff have access to a personal alarm.

The provider should ensure that there is adequate staffing on the weekends.

The provider should continue to ensure that searches are based on risk assessments according to the service's policy.

The provider should ensure that all staff have a good understanding of the Mental Capacity Act and Code of Practice and can apply these principles in practice.

The provider should ensure feedback patients raise in community meetings are actioned on in a timely manner.

The provider should consider how they engage with patients whose first language is not English and ensure they give patients the opportunity to provide regular feedback about the service.

The provider should ensure that all patients have a discharge plan in place.

The provider should ensure that processes are available for staff to report bullying and harassment and that they deal with any cases appropriately.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured that patients were protected against the risk of ligatures.** **This was because there was no ligature risk assessment available and some staff were not aware of ligature risks.** **This was a breach of Regulation 12 (1)(2)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider had not ensured that there was a system in place to identify, receive, record, handle, respond to and learn from complaints.** **This was because all complaints were resolved informally and not centrally located. The provider had no record of any formal complaints made in the past year. Some patients wanted to make a complaint but did not know how to or would not feel comfortable to make a complaint.** **This was a breach of Regulation 16 (1)(2)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had not ensured that there were systems in place to records were complete, accurate and up-to-date**

This section is primarily information for the provider

Requirement notices

including patient's care records, staffing rotas, staff supervision, training records, and community meeting minutes. There was no joint-working agreement in place between Partnerships in Care 1 Ltd. and BEH trust.

This was a breach of Regulation 17 (1)(2)(c)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not submitted statutory notifications to the CQC regarding safeguarding alerts and incidents reported to the police. This was a breach of Regulation 18 (2)(e)(f)