Regency House Limited

The Huntercombe Hospital - Roehampton

Quality Report

Holybourne Avenue,
London
SW15 4JL
Tel: 020 8780 6155
Website: www.fshc.co.uk

Date of inspection visit: 29-31 July 2015
Date of publication: 03/11/2015

This report describes our judgement of the quality of care at this hospital. 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 hospital	Requires improvement 
Acute wards for adults of working age and psychiatric intensive care units	**Requires improvement** 
Services for people with acquired brain injury	

Summary of findings

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:

- There were not always enough staff on Richmond ward to deliver safe, high quality care and treatment.
- Many staff were not up to date with mandatory training requirements.
- Staff on Richmond ward did not always complete patient risk assessments consistently. The reasons for changes in level of patient risk were not recorded or explained.
- One bedroom was in a very poor physical state and not safe for patient use.
- Policies for seclusion and long term segregation had not been updated to reflect the current Mental Health Act code of practice.

However,

- On Kingston ward, staff shared individual risk assessments with patients, which enabled them to see a visual representation of their progress towards recovery.
- Staff knew how to report incidents and there was evidence of learning from them.
- The service was working towards reducing the number of times patients were restrained.
- The service checked whether staff were suitable to work with patients before they started work.

Are services effective?

Requires improvement 

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

- Patient care plans on Richmond ward were not personalised and did not reflect the individual needs and preferences of patients. Patients were not involved in developing their own care plans.
- When staff gave patients 'as required' medicines they did not always clearly document the reasons for this in the patient's clinical notes.
- Some staff on Richmond ward did not receive regular supervision.
- Staff on some wards did not fully understand mental capacity legislation and guidance and how it applied to their practice.
- Staff were not proactive in promoting alternatives to smoking, such as nicotine replacement therapy.

Summary of findings

However,

- On Kingston ward, staff had developed a booklet that recorded patients' attendance at, and level of engagement with, activities.
- Staff explained patients' rights to them in a way they could understand.
- On Hampton ward, the care plans for acute patients were holistic, recovery orientated and up to date. There was good recording of patient involvement and patient views.

Are services caring?

Good

We rated caring as **good** because:

- Patients and carers were positive about staff and described them as patient and caring.
- Staff and managers listened to patients' suggestions.
- Patients had access to an independent advocate.
- In a recent survey, 92% of patients said they had been treated with dignity and respect by staff.

However,

- There was a risk that the privacy and dignity of patients being taken into the de-escalation or seclusion rooms would not be maintained when other patients were in the dining room.
- Some patients felt they were not as involved in their care as much as they wanted to be.
- The minutes of community meetings on Richmond ward were not easily accessible to patients.
- On two occasions, staff on Richmond ward spoke abruptly to patients, although this was not typical of the staff and patient interactions we observed on all three wards.

Are services responsive?

Good

We rated responsive as **good** because:

- The service was flexible and patients could usually be admitted at short notice.
- Patients could take part in a wide range of activities.
- Patients knew how to complain. An easy read version of the complaints leaflet was available. This made it easier for patients to make a complaint.

However,

- In a recent survey patients raised concerns that there were not enough snacks and drinks available during the day and overnight.

Summary of findings

- There was a lack of assurance that meals were always prepared according to religious requirements.
- Final complaint response letters did not always tell people about the options they had if they were unhappy with the outcome of their complaint.

Are services well-led?

Requires improvement

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

- The systems and processes used to assess and monitor standards of care were not always effective in bringing about improvements in quality and safety.
- Audits of patient records had highlighted concerns about the quality of care plans but this had not led to improvements. Care plans on Richmond ward were not individualised or person centred.
- Pharmacy audits had highlighted concerns about medicine errors. This did not lead to improvements. A second audit three months later identified a similar high number of medicine errors.
- The service had not recorded information about the number of incidents of patient restraint and seclusion consistently. Numbers reported to us prior to the inspection were different from those reported in integrated governance meeting minutes.

However,

- The hospital was going through a period of considerable change. A new senior management team had been in place for six weeks. New systems of oversight, assessment and monitoring of care and treatment were being introduced.
- Some staff had good understanding of duty of candour requirements.
- Staff had confidence in their ward managers and felt supported by them.

Summary of findings

Our judgements about each of the main services

Service	Rating
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement 

Why have we given this rating?

We gave an overall rating of **requires improvement** because**:**

- There were not always enough staff on Richmond ward to deliver safe, high quality care and treatment.
- Many staff were not up to date with mandatory training requirements.
- Staff on Richmond ward did not always complete patient risk assessments consistently. The reasons for changes in level of patient risk were not recorded or explained.
- Patient care plans on Richmond ward were not personalised and did not reflect the individual needs and preferences of patients.
- When staff gave patients 'as required' medicines they did not always clearly document the reasons for this in the patient's clinical notes.
- The systems and processes used to assess and monitor standards of care were not always effective in bringing about improvements in quality and safety.

However,

- On Kingston ward, staff shared individual risk assessments with patients which enabled them to see a visual representation of their progress towards recovery.
- On Kingston ward, staff members had developed a booklet that recorded patients' attendance at, and level of engagement with activities.
- Staff knew how to report incidents of harm or risk of harm and there was evidence of learning from them.
- The service was working towards reducing the number of times patients were restrained.
- Patients and carers were positive about staff and described them as patient, professional and caring.
- The service was flexible and patients could usually be admitted at short notice.

Summary of findings

- Patients could take part in a wide range of activities.
- Patients knew how to complain. An easy read version of the complaints leaflet was available. This made it easier for patients to make a complaint.
- The hospital was going through a period of considerable change. A new senior management team had been in place for six weeks. New systems of oversight, assessment and monitoring of care and treatment were being introduced.

Services for people with acquired brain injury

We inspected the service provided to patients with acquired brain injury on Hampton ward but we did not rate this service because there were very few patients with the condition admitted to the hospital. There were four patients with acquired brain injury admitted to the ward and three patients with acute mental health problems. The service for patients with neuro-psychiatric problems/acquired brain injury was due to be discontinued and suitable alternative placements were being sought for the four patients.
We found:

- Many staff were not up to date with mandatory training requirements.
- The systems and processes used to assess and monitor standards of care were not always effective in bringing about improvements in quality and safety.

However,

- Staff knew how to report incidents of harm or risk of harm and there was evidence of learning from them.
- Staff understood the needs of patients with acquired brain injury well.
- Patients and carers were very positive about staff and described them as patient, professional and caring.
- Patients could take part in a wide range of activities.

Summary of findings

- Patients knew how to complain. An easy read version of the complaints leaflet was available. This made it easier for patients to make a complaint.
- The hospital was going through a period of considerable change. A new senior management team had been in place for six weeks. New systems of oversight, assessment and monitoring of care and treatment were being introduced.

Requires improvement

The Huntercombe Hospital - Roehampton

Detailed findings

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; and Services for people with acquired brain injury.

Detailed findings

Contents

Background to The Huntercombe Hospital - Roehampton

The service provides two psychiatric intensive care units (PICU), one for men and one for women, and a specialist neuro-psychiatry and brain injury ward. The hospital has a total of 39 beds over the three wards.

Kingston ward is a 14 bed male PICU; Richmond ward is a 14 bed female PICU and Hampton ward is an 11 bed neuro-psychiatry and acquired brain injury ward. There were seven patients admitted to Hampton ward during the inspection. Four of the seven patients were neuro-psychiatric patients. The other three were patients with acute mental health problems who no longer needed to be cared for in a PICU environment. The purpose of the neuro-psychiatry ward was in the process of changing at the time of the inspection. It was due to become a PICU. The service was looking for suitable alternative placements for the four patients with acquired brain injury.

On the days of the inspection there were 33 patients admitted to the hospital. All patients were detained under a section of the Mental Health Act.

We have inspected The Huntercombe Hospital – Roehampton four times since 2010 and reports of these inspections were published between March 2012 and March 2014. At the last inspection The Huntercombe Hospital – Roehampton was meeting essential standards.

Our inspection team

Team leader: Judith Edwards, Care Quality Commission.

The team that inspected The Huntercombe Hospital consisted of 12 people, two inspection managers, four inspectors, a senior nurse, a social worker, a psychologist, a mental health act reviewer and two experts by experience. The experts by experience are people who had developed expertise in relation to health services by using them.

How we carried out this inspection

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

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

Detailed findings

- 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:

- visited all three wards of the hospital and looked at the quality of the ward environment
- spoke with 15 patients admitted to the wards
- spoke with five carers or relatives of patients
- spoke with senior managers of the service and the three ward managers
- spoke with 31 other staff working in the service, including doctors, nurses, health care support workers, a social worker, a psychologist, an occupational therapist, the head chef and an administrator
- looked at 17 care and treatment records of patients
- observed how staff were caring for patients
- attended a ward community meeting
- observed two ward based activity groups
- carried out Mental Health Act monitoring visits on Hampton and Kingston wards
- collected feedback from 17 patients using comment cards
- received feedback about the service from 11 care-coordinators or commissioners
- received information from an independent mental health advocate and
- looked at a range of records, policies and documents relating to the running of the service.

Facts and data about The Huntercombe Hospital - Roehampton

The Huntercombe Hospital – Roehampton is provided by Regency House Limited. It is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983;
- Accommodation for persons who require nursing or personal care;
- Diagnostic and screening procedures; and
- Treatment of disease, disorder or injury.

There was no registered manager in place at the time of the inspection as they had recently left. The provider was in the process of recruiting a new manager for the hospital.

Our ratings for this hospital

Our ratings for this hospital are:

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

Requires improvement

Are services safe?

Our findings

Safe and clean environment

- Each ward was well designed with a good layout. There were clear lines of sight from the nursing offices so that staff could see where patients were. However, on Richmond ward, the female PICU, the lines of sight along the bedroom corridors were sometimes blocked by bedroom doors that had been left open. These blocked the view along the corridor, which could mean that some patients were out of sight of staff.
- Each ward had a thorough ligature risk assessment. This identified which places to which patients might tie something to harm themselves. The assessments detailed the ligature risks and how they were mitigated and minimised. However, we found two ligature risks on the wards that had not been identified. We reported this to ward staff who took immediate action to include the risks in the ligature risk management plan. Patients on Hampton ward, where four of the patients had an acquired brain injury, were generally considered to be of low risk of suicide or self-harm. Staff managed ligature risks by keeping some rooms locked when not in use and by completing individual risk assessments so that appropriate measures could be taken to minimise the risk for each patient.
- Each ward had a fully equipped clinic room. Emergency equipment was available and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Emergency medication was in place and in date. Staff had received training in life support techniques and use of the automated external defibrillator to enable them to respond competently to emergencies.
- Blood glucose machines were used to test some patients' blood sugar levels. These machines had not been calibrated recently on any of the wards. This meant the machines may not have been recording accurately. We informed the ward staff of this. The provider took immediate action to begin calibration of these machines during the inspection. Other equipment was maintained at regular intervals and appeared clean. However, there were no records or labels indicating a regular cleaning schedule or when equipment had last been cleaned.
- The PICUs shared a de-escalation room and two seclusion rooms. Seclusion rooms are used for the supervised confinement of a patient to contain severely disturbed behaviour likely to cause harm to others. The de-escalation room was situated between the two seclusion rooms. All of the rooms were well decorated, well-maintained, and clean. Neither seclusion room had a two way intercom that would allow a patient in the seclusion room to communicate with staff outside. However, it was possible to communicate without an intercom if speaking loudly.
- The wards were spacious, with good décor and were generally well maintained. Furniture was comfortable and visibly clean. A recently decorated bedroom on Richmond ward was bright and colourful. However, one bedroom was in a poor state of repair and cleanliness. The flooring had peeled back to reveal concrete. This was a trip hazard. The magnetic door closer was loose. There were stains and marks on the wall and a fabric seat on a chair was dirty. When we raised concerns about the room with staff the patient was moved to another room and the bedroom closed.
- Cleaning schedules were maintained and showed that regular cleaning took place on the wards. On Richmond ward weekly cleaning tasks were not always undertaken in a systematic way. This meant some tasks had not been undertaken for over four weeks. The occupational therapy kitchen did not have a separate hand wash basin.
- The hospital infection control audit report dated 3 June 2015 identified overall compliance with infection prevention and control standards varied between 69% and 75% across the three wards (Kingston ward 69%; Richmond ward 70% and Hampton ward 75%). The report identified that staff had not undertaken hand hygiene training in the last year. Cleaning of medical equipment required monitoring. There was no evidence that clinical waste was being separated appropriately and clinical waste bags were not labelled. Some bedrooms on all wards were without waste bins. Containers for disposing of sharp implements, such as needles, were not always correctly assembled or labelled. Recommendations for improvements in practice had been made and an action plan put in place. Infection control standards were due to be audited again in September 2015.

Requires improvement

Are services safe?

- A legionella risk assessment audit had been completed in May 2014. The report identified a number of risks. A re-assessment of legionella risks had taken place in January 2015. Controls had been put in place to manage the risks. These included weekly water sampling and on-going flushing of all water outlets.
- The hospital had been awarded a food hygiene rating of five (very good) by the local authority in May 2014.
- Environmental risk assessments were undertaken on a regular basis. Where concerns were identified these were addressed.
- A fire risk assessment had been carried out at the hospital in September 2014. The fire risk assessment identified a number of risks. These had been addressed by the service to ensure fire risks were being managed safely. Measures were in place to ensure the safe evacuation of patients and staff from the building in the event of a fire.
- Staff carried personal alarms to summon assistance. The alarms indicated whether staff required general or urgent assistance.

Safe staffing

- The provider submitted information prior to the inspection showing that the total number of substantive staff for the hospital was 100 (as at 1 April 2015). The total number of staff leaving in the previous 12 months was 30. Staff turnover from April 2014 – March 2015 was 33% of all substantive staff. The provider revised this figure to 16.3% of substantive staff after the inspection. The initial figure had included bank staff who had left during the year.
- Staff vacancy rates were 7% at the beginning of April 2015. There were three vacancies for qualified nurses across the service at the time of our inspection. Two of these were on Richmond ward and one on Hampton ward.
- The overall staff sickness level from April 2014 – March 2015 was 3%.
- On Hampton ward during the day there was a minimum of two qualified nurses and three health care support workers on duty. At night there were two qualified staff members and two health care support workers. These staffing levels had been estimated using a recognised tool and were sufficient to meet the needs of patients. The number of staff on duty reflected the staffing roster.
- Each PICU was led by a nurse manager. Eleven nurses and 14 health care support workers worked on each ward. On Kingston ward there was a full complement of nursing staff. On Richmond ward, there were two vacancies for nurses, which had been advertised.
- Staffing levels were adjusted so that when there were more patients there were more staff on duty. When a patient needed one to one support or observation from staff, an additional staff member was obtained. On Richmond ward, it was common for three or four patients to require one to one support at the same time.
- On Kingston ward, the manager ensured there were sufficient staff with the right skills every day. The ward was rarely short of staff. However, on Richmond ward, there was sometimes a shortage of staff compared with the safe staffing levels set by the hospital. Between 6 July 2015 and 31 July 2015 there had been 10 days on which the number of staff on duty on Richmond ward had not met safe staffing levels during the day. This represented 38% of day shifts. On these days, the ward was short of one, two or three staff. There had been occasions when one qualified nurse was on duty instead of the two nurses specified by safe staffing levels. Two patients reported that staff were overworked and there were not enough staff. Staff confirmed this. Two patients and a member of staff reported that they did not always feel safe on the ward.
- We observed Richmond ward when it was short of staff and when it was fully staffed. When it was short of staff, staff were not always visible in the lounge area. Staff had limited ability to observe patients and anticipate incidents. The ward was potentially unsafe for patients. When the ward was fully staffed, staff were visible and patients were less distressed.
- The hospital used bank, and sometimes agency, nursing staff to cover for staff sickness, leave and vacancies. They also worked when patients required continuous, one to one support. Bank staff were permanent staff working additional shifts or staff who undertook shifts

regularly at the hospital. When there were no bank staff available, agency nursing staff were used. These were sometimes staff who did not know the hospital or patients.

- In the three months prior to our inspection114 shifts had been covered by 'bank' or agency staff. Most of these staff had been required to carry out continuous observations on patients needing one to one care.
- A ward doctor was available weekdays between 9am and 5pm. There were five middle grade doctors providing on-call medical cover at night. They were required to attend within one hour if needed. Consultant psychiatrists were second on call and would also attend the hospital when needed. Admissions were accepted out of hours and it was not uncommon for a doctor to be present in the hospital during the weekend or at night. Staff reported no difficulties in obtaining medical advice at short notice.
- We reviewed the personnel files of five staff working in the service. Records showed that checks were carried out on staff before they started working in the service to confirm that they were suitable to work with patients. These included checks with the disclosure and barring service, two references from previous employers and photographic proof of identity. The service checked prospective employees' qualifications and registration. However, this only applied to professionally qualified staff. Health care support workers and staff working in the facilities department were not required to provide proof of their qualifications. Any gaps in employment history and the reasons for these were recorded in four of the five records we reviewed. There was no explanation regarding a gap in employment history in the file of one staff member.
- Administrative staff at the hospital checked that agency staff had completed training in how to safely restrain a patient and developed a staff profile. Agency staff received an induction and orientation to the hospital before working on the wards. This helped ensure they understood hospital procedures, including what to do in an emergency.
- Staff were expected to complete mandatory training in a range of areas. The hospital sent us information about staff completion of mandatory training in 15 areas for each ward. This showed that most staff had completed training in basic or intermediate life support, 'five day team work' and promoting safer and therapeutic services (which included how to restrain a patient safely). However, completion of manual handling training varied between 45% on Hampton ward and 63% on Richmond ward. On Kingston ward 52% of staff had completed customer care training and 43% had completed training in deprivation of liberty safeguards. On Hampton ward 45% of staff had completed customer care training and 55% deprivation of liberty safeguards. Overall, on Richmond ward less than 75% of staff had completed training in nine of the 15 mandatory areas. Similarly, on Kingston ward less than 75% of staff had completed training in nine of 15 mandatory areas. On Hampton ward, less than 75% of staff had completed 12 out of 15 mandatory training sessions. This meant there was a risk that staff did not have the necessary knowledge and skills to provide safe care.
- Records showed that large numbers of 'bank' staff had not completed mandatory training in most areas. For example, only 22% had completed breakaway training, 49% had received training in basic or intermediate life support, 19% had completed engagement and observation, and 19% safeguarding vulnerable adults training. However, it was difficult to draw conclusions from the figures as a number of identified staff no longer worked at the hospital but had not been removed from the list of 'bank' staff available.
- Some mandatory staff training was provided electronically. This included training in fire safety, health and safety and infection prevention and control. Information provided by the hospital showed that 45% of staff were up to date with fire safety training, 59% with health and safety training and 60% with infection prevention and control. Significant numbers of staff had not completed this training in the last year. This meant they may not have been up to date with current procedures and lack the necessary knowledge and skills to protect patients.
- Staff had not received child safeguarding training as this had only just been introduced as a mandatory subject. There was a potential risk to the children of patients and others if staff did not recognise potential abuse or know what action to take if they had concerns.

Assessing and managing risks to patients and staff

Requires improvement

Are services safe?

- In the previous six months there had been 307 potential or actual violent incidents. In 58% of these incidents, staff were recorded as having attempted to deal with the incident by de-escalation. In 34% of incidents staff used the least restrictive form of restraint, known as 'precautionary holds.' In 9% of incidents the most restrictive form of physical restraint was used.
- The hospital was monitoring the use of physical restraint on a monthly basis. Audits of the number of restraint incidents in 2015 showed a reduction between the first and second quarters. From January to March 2015 there had been 25 incidents of restraint. Twenty of these had been in the 'prone' or face down position (14 on Richmond ward and six on Kingston ward, the two PICUs). From April to June 2015 there had been 18 restraints recorded, 15 of which had been in the 'prone' or face down position (11 on Richmond ward and four on Kingston ward). The research, audit and development committee had reviewed a detailed breakdown of restraint practices in order to identify continued improvements needed in practice.
- The provider's reducing restrictive intervention steering group was responsible for overseeing an action plan aimed at reducing the number times physical restraint was used. There was a particular focus on reducing the use of 'prone' or face down restraint. The work plan outlined actions aimed at reducing incidents of seclusion and other restrictions on patients.
- The provider had policies for seclusion and long term segregation. However, neither policy had been updated to reflect the current MHA Code of Practice. Long term segregation was not identified as a form of seclusion in the policy. The provider had an overarching policy for physical interventions as well as a local policy. The local policy provided more detailed information. However, it did not have a date of publication. The provider was in the process of updating the policies at the time of the inspection.
- There were nine incidents of seclusion recorded in the previous six months. Six of these had occurred on Kingston ward and three on Richmond ward.
- Seclusion records showed that de-escalation had been attempted with patients prior to seclusion being used.
- Seclusion records were completed in full. Nursing and medical reviews took place in accordance with the MHA code of practice. Seclusion care plans were not used. However, staff informed patients of how seclusion could end. Seclusion was ended as soon as possible and the patient could be cared for safely on the open ward.
- The use of rapid tranquilisation on the PICUs had reduced significantly over the previous six months. Between January and March 2015 rapid tranquilisation had been used 37 times (26 times on Richmond ward and 11 times on Kingston ward). From April to June 2015 rapid tranquilisation had been used 13 times (11 times on Richmond ward and twice on Kingston). This was a reduction of more than 50%. Rapid tranquilisation had not been used on Hampton ward in the previous six months.
- A risk assessment tool was used to assess each patient's risks when they were admitted to hospital. The tool listed a range of potential risks. There was a rating scale to measure the severity of the risk. These were usually updated at each weekly ward round. Senior managers explained that the risk assessment tool had been introduced in June 2015, a month before the inspection. Training had been provided to ward managers and was being cascaded to other staff through one to one supervision sessions. One group training session had been held for 16 nurses in July 2015.
- On Kingston ward there were detailed risk assessments in place for each patient. Staff used an individual graph to collate risk assessment scores for a patient. This provided a visual tool for patients to enable them to better understand the risks affecting them and see their own improvement and progress. On Hampton ward staff completed and regularly updated risk assessments for patients. Where particular risks had been identified, management plans were put in place to support the patient to manage the issues.
- However, on Richmond ward we found risk assessments were completed inconsistently. We reviewed the risk assessments of four patients in the ward in detail. Risk assessments had been completed by a nurse and separately by the multi-disciplinary team (MDT). Risk assessments had taken place on consecutive days but the risks identified were significantly different. Some risks were identified as high on one day and then removed from the tool the next day without explanation. The severity of some risks was rated differently without explanation of how they had been

assessed. For example, the risk assessment of one patient dated 28 July 2015, completed by a nurse, identified the level of risk associated with their physical health as 'serious.' On 29 July 2015 a risk assessment for the same patient, completed by the MDT, assessed the risk related to the patient's physical condition as 'low', even though they had a long term physical health condition. For a second patient staff had completed four risk assessments using the new tool over the course of seven days. On 22 July 2015 the patient's risk to children was not identified as a risk by the MDT. On 23 July 2015 the risk to children was rated as 'serious' by a nurse. On 27 July 2015 the risk to children was again not identified as a risk by the MDT. On 28 July the patient's risk to children was rated as 'significant' by a nurse. Clinical records did not provide an explanation of how risks or their severity had been assessed or why they had changed. There was a risk that patient risk assessments were not completed accurately and individual risks not appropriately managed or mitigated.

- Safeguarding adults was mandatory training for staff. Overall, 65% of staff on all wards were up to date with the training. The safeguarding policies and procedures were easily accessible to staff. A hospital social worker had a clear role where there were safeguarding concerns. They usually worked jointly with clinicians in these circumstances. Richmond ward clinical improvement group meeting minutes from May 2015 noted that there was sometimes a delay of three or four days in sending safeguarding alerts to the local authority safeguarding team because staff lacked the confidence to make alerts independently. Staff usually raised safeguarding concerns via the hospital social worker. This had caused delays at weekends and when the social worker was on leave. The social worker had agreed to provide training to staff on all wards to enable them to raise alerts directly with the relevant safeguarding team. Staff understood which events should prompt a safeguarding referral.

- Overall, medicines were managed effectively on the wards. There was a clear process for ordering and supplying medicines and staff knew the process. Patients' prescription folders had a photograph of them attached to ensure the right patient received the right medicines. Room and drug fridge temperatures were recorded daily. This ensured that medicines were stored at the correct temperature and remained effective to use. However, on Hampton ward, some medicines which were no longer required had not been disposed of. In addition, controlled drugs were being checked weekly rather than daily by staff. On Richmond ward, a patient's tobacco was kept in the controlled drug cupboard, which was inappropriate. This was removed during the inspection.

- We reviewed the medicine administration records of three patients on each ward. Staff had signed the record when medicines had been given to patients or had recorded the reason why it had not been given.

- At the time of the inspection there were seven patients on Hampton ward. Four patients had an acquired brain injury/neuro-psychiatric conditions and three had acute mental health problems but did not need to be cared for in a PICU. Staff had carried out risk assessments to ensure that the acute patients could be cared for safely on Hampton ward and patients with acquired brain injury would not be put at risk. Hampton ward was in the process of changing its function and was scheduled to become a PICU within the next six months. Plans were being made to transfer patients to suitable alternative accommodation.

- On Richmond ward a water dispenser was available for patients. Patients had to request cups for the dispenser from staff in order to obtain a drink of water. Staff told us this was due to the potential risk that patients could use the cups to harm themselves. We observed patients knocking on the ward office door to attract staff attention and ask for a cup. They sometimes had to wait for several minutes before being attended to, especially if staff were busy. When we raised this with the hospital manager during the inspection, they said they would obtain suitable cups that were safe for patients to use and that could be left on the ward. This would allow patients to obtain a drink of water when they wanted one.

Track record on safety

- There was one serious incident recorded in the last six months. This related to the unexpected death of a patient on Hampton ward.

- There had been no serious incidents on Richmond or Kingston wards within the previous 12 months. Just

prior to this period there had been a serious incident on Richmond ward. Following an investigation, a number of changes had been made to minimise chances of reoccurrence.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. Incident reports were reviewed by senior managers and investigated by the most suitable manager. Learning was identified and discussed at multi-disciplinary team meetings, clinical improvement groups and ward handover meetings. Learning from incidents led to improvements in care and informed the training of staff. Action plans resulting from serious incidents were reviewed and updated. Staff recorded when agreed actions had been completed. Staff and managers were confident that all incidents that should have been reported were reported.
- Staff received support after a serious incident, including support to seek medical advice if needed, a debrief meeting and opportunities for reflective practice. Staff on Kingston ward spoke of debriefing as an opportunity to learn. The incident was reviewed and improvements identified. However, when we reviewed 10 debriefing records on Richmond ward only one of these records contained information in the section identifying 'lessons learned'. The other nine did not. A number of incidents had occurred where there was no debriefing record.
- The hospital received immediate alerts from the provider concerning serious incidents that had taken place in other services. This allowed learning from incidents to be shared more widely and helped prevent incidents happening again. The provider held a monthly conference call with all services in the Huntercombe group. This included discussion of any serious incidents.
- In April the service had introduced a new, more robust, system for recording incidents. This aimed to improve the consistency of incident reporting and the reliability of information collected about the service, such as the number of incidents, restraints and episodes of seclusion.

Requires improvement

Are services effective?

Our findings

Assessment of needs and planning of care

- We reviewed the care records of 17 patients across all three wards. Patients had been comprehensively assessed on admission. Assessments included both physical and mental health. Mental state assessments included a global assessment of functioning.
- Assessments of patients' physical health involved a physical examination by a doctor and blood tests as required. All patients had an electrocardiograph (ECG) to detect any heart abnormalities. All 11 care co-ordinators and commissioners we spoke with prior to the inspection considered the physical health care needs of patients were addressed effectively by the service. Patients' physical health needs were monitored on an ongoing basis.
- All patients had a 72 hour care plan in place. This was to ensure the patient was safe whilst their needs were assessed.
- On Hampton ward the care plans for the acute patients were holistic, recovery orientated and up to date. There was good recording of patient involvement and patient views. The four patients with neuro-psychiatric problems on Hampton ward had a blue folder that contained documents relevant to their care. These included their care plan, risk assessment and physical health assessment. This ensured they had easy access to their information. They could take ownership of this information and share it with others. For example, this would be taken for GP visits and to show cares or relatives. The care plans for patients with neuro-psychiatric conditions were detailed, purposely designed to meet the needs of this patient group and contained good information regarding patient involvement.
- We reviewed care plans of five patients on Kingston ward. The care plans were personalised to the patient and recovery oriented. They addressed the patients' needs, were detailed and specific. The risks patients' presented were addressed in their care plans.
- On Richmond ward we reviewed the care plans of five patients in detail. Most care plans for the five patients were the same. They were not personalised to the patient. Patients' needs were recorded as their diagnosis or the behaviour they displayed. The patients' actual needs were not recorded accurately, and there was limited detail.
- Care plans on the ward appeared to be written for staff rather than the patient. For example, one patient had a care plan that focussed on staff being able to safely restrain the patient. This did not meet the patient's assessed needs. Staff used abbreviations in the care plans which the patient would be unlikely to understand. We observed a patient being told by staff that their outgoing phone calls were restricted to two calls a day and would be supervised by staff. There was no care plan in place for the individual regarding this restriction. The reason for the restriction, and when this was to be reviewed, was not recorded. Some patients were a considerable distance from home. Several patients told us this caused them significant distress. None of the patients had a care plan in place concerning this. There was little recording of patients' views, strengths, personal concerns or goals in any of the Richmond ward care plans.
- Some patients were prescribed 'as required' medicines. These were medicines which were not given regularly, only when needed. On Richmond ward, the reasons why the patient needed 'as required' medicines were not always recorded clearly. Sometimes the reasons were vague, or not recorded in the clinical notes. In some cases, the patient was described in such a way that indicated no 'as required' medicines were needed. However, medicine administration records showed that they had been given by staff. For example, the medicine administration record of one patient indicated they had received 'as required' medicine on five occasions between 20 July 2015 and 25 July 2015. There was a record in the patient's healthcare notes showing they had been given 'as required' medicine on one of these occasions. On the other four occasions there was no written record in the patient's notes that 'as required' medicine had been administered or considered necessary. This was similar for a second patient who had been given 'as required' medicine but the reason for this was not recorded in their clinical notes. On another occasion, records of a patient on Richmond ward showed they had been given 'as required' medicines

after they had refused to engage or speak with staff or consent to a property check when they were admitted to the ward. The appropriateness of this treatment was not supported by the clinical record.

- Patient care records were paper based only. The records were stored securely in the nursing office on each ward. Some important patient information was displayed on a board in the nursing office. However, this board could only be seen by staff. It was kept covered when not in use. This meant information concerning patients was kept confidential.

Best practice in treatment and care

- Staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions. For example, when prescribing medicines and providing psychological interventions.
- The service had carried out an audit of therapist contact with patients on the wards. From January to March 2015 therapists, including clinical psychologists and occupational therapists, spent 55% of their working hours directly engaged in either group or individual activities with patients. Richmond ward (female PICU) received 610 therapist contact hours during the quarter. Whereas Kingston ward (male PICU) received 328 hours of therapist contact hours for the same time period. The service aimed to increase therapist patient contact to 70% of therapist working hours and ensure greater consistency across the wards. A re-audit was planned for August 2015.
- Patients on Hampton ward had access to a psychologist and were offered support on an individual basis. The psychology department developed recovery focused programmes for patients. These were planned according to patients' interests. Staff considered how to engage those patients who lacked motivation or had limited insight into their own mental health.
- Staff used health of the nation outcome scales to measures outcomes for patients. The occupational therapist used the model of human occupation screening tool to evaluate the progress of patients.
- On Kingston ward, staff members had developed a booklet that was used to record patients' attendance at, and level of engagement in activities. This helped staff monitor the progress of patients.
- Patients had access to specialist care when needed. Staff sought specialist advice where patients had an abnormal test results. Staff arranged further investigations and appointments for patients with physical health concerns.
- We saw little evidence on the wards that patients were actively supported to stop or reduce smoking although nicotine replacement therapy was available on request. However, senior managers told us that the hospital had a dedicated lead for smoking cessation. Eleven patients had been provided with support to reduce or stop smoking over the previous year.
- Staff participated in clinical audits. These were conducted on a regular basis. For example, there were annual audits of case notes and quarterly pharmacy audits.

Skilled staff to deliver care

- Care and treatment was delivered by a team of multi-disciplinary professionals. These included nurses, doctors, occupational therapist, sports instructor, psychologists and social worker. Members of the team were experienced in providing support and treatment for patients.
- On Hampton ward staff received monthly management and clinical supervision and, where needed, this was arranged externally to the hospital. On Kingston ward, nursing staff received supervision monthly. When a supervisor was on leave, the supervisor's 'buddy' undertook supervision. Supervision was also provided to bank staff on the ward. On Richmond ward, supervision was less frequent. Eight nursing staff had received supervision only twice in the previous six months. Five staff members had received supervision three times. There was a risk that staff on Richmond ward were not receiving sufficient support to carry out their duties effectively.
- The percentage of non-medical staff who had received an appraisal in the last 12 months was 83%. Five of the 23 staff on Hampton ward had not had an appraisal but these were planned.
- Five of the six doctors employed in the service had undergone professional revalidation in the last year. The other had been on long term leave.

Requires improvement

Are services effective?

- Some staff had undertaken training in addition to mandatory training to support their professional development. This included training so that staff could defuse potentially violent incidents. Some staff had attended a communication skills workshop. This had been facilitated by the psychologist. Other ward staff had been trained to supervise the gym and assist patients with cooking. One staff was undertaking a mentorship course at a local university and two qualified staff were due to attend the national association of psychiatric intensive care and low secure units (NAPICU) quarterly meeting, which was an opportunity for further professional development.
- All new staff received an induction when starting work on the wards. Bank staff also received an induction. This ensured that all staff working on the wards were familiar with ward routines and hospital policies before working more independently.
- Each ward had a regular team meeting for nursing staff. Various operational issues were discussed in these meetings.
- Staff performance issues were addressed through ongoing supervision. There were no staff performance issues reported at the time of the inspection.

Multi-disciplinary and inter-agency team work

- Ward rounds occurred twice per week on Kingston and Richmond wards and were attended by members of the multi-disciplinary team. There were weekly multi-disciplinary meetings on Hampton ward. Staff reported that the different professionals worked well together. Patient records showed evidence of multi-disciplinary input.
- Communication with other agencies and organisations varied. There were established links with the cardiology department at the local general hospital, which enabled patients to have relevant physical health tests when they needed them. However, communication with patients' care co-ordinators was not consistent. We spoke with 11 care-co-ordinators and commissioners of the service prior to the inspection. Five care co-ordinators raised concerns about the quality of communication they had with hospital staff and said they were not always well informed about the progress of their patients. However, others told us the opposite and said they worked well with hospital staff.

Adherence to the MHA and MHA Code of Practice

- A Mental Health Act Reviewer carried out a review of the use of the Mental Health Act on Kingston and Hampton wards during the week of the inspection.
- Sixty six per cent of staff had received training in the Mental Health Act 1983 (MHA). Staff showed a good understanding of the Mental Health Act, Code of Practice and guiding principles.
- The use of the Mental Health Act (MHA) in the service was good. MHA documentation was filled in correctly, was up to date and stored appropriately. Certificates showing that patients had consented to their treatment (T2), or that it had been properly authorised (T3), were completed and attached to medicine charts where required.
- On admission, patients' rights were explained to them by staff in a way they could understand. This was repeated at regular intervals. In the majority of patient records there was evidence of discussions of rights every month. Patients had access to an independent mental health advocate who could support them. Posters were displayed on the wards, advertising this service to patients.

Good practice in applying the MCA

- The hospital had a policy in place to inform and support staff in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Most staff members had completed training in MCA and DoLS. However staff on Hampton and Richmond wards lacked understanding of the legislation, guidance and assessment process. On Kingston ward, nursing staff had a good understanding of the MCA.

Good

Are services caring?

Our findings

Kindness, dignity, respect and support

- In a recent patient satisfaction survey completed in June 2015, 92% of patients from all wards, who responded, said they had been treated with dignity and respect by staff.
- On Hampton ward staff demonstrated compassion for the patients they supported. Staff knew the patients and their needs very well. Patients were positive about the care they received from staff. We spoke with five patients on Hampton ward, some of whom had an acquired brain injury. Patients spoke positively about the staff on the ward. They said staff helped and supported them. Patients described staff as patient, professional and caring.
- We spoke with 10 patients on Kingston and Richmond wards. Patients on Kingston ward spoke positively about the staff and their care and treatment. However, some patients on Richmond ward were less positive. Two patients described staff entering their bedrooms without knocking on the door first.
- We observed positive interactions between staff and patients on the PICUs. Staff spoke with patients in a supportive and respectful manner particularly on Kingston ward. However, on Richmond ward we observed some less positive interactions. On two occasions, staff spoke abruptly with patients. We noted these interactions occurred when the ward was short of staff. When the ward was fully staffed, such interactions did not occur.
- We collected sixteen comment cards, all from Richmond ward. Seven comment cards commented on staff. Four of the cards were positive, saying that staff listened and were helpful. Two comment cards reported the opposite. The other card contained mixed views. When patients were discharged they were invited to write comments in a 'feedback' book. There were a number of comments praising staff.
- A significant number of the patients at the hospital were not from the London area and this meant that carers might have difficulty in visiting their relatives as often as they would like. The hospital had taken a flexible approach to visiting times because of this. Carers were provided with transport to and from the local train station. The hospital also provided patients with escorted home visits to their home area, which meant that the patient was able to retain relationships with family and friends. We spoke to five relatives or carers. Four of the five commented that staff were caring and interested in the well-being of their relatives.
- The de-escalation and seclusion rooms were situated opposite the entrance to the dining room used by patients from the PICUs. The door to the dining room had windows. This meant that patients in the dining room could potentially see a patient being taken into the de-escalation or seclusion room when the dining room was in use. Staff had not taken any action to mitigate this and ensure arrangements were in place to maintain the privacy and dignity of patients being taken into the de-escalation or seclusion rooms at meal times.

The involvement of people in the care they receive

- On Hampton ward patients were routinely involved in their care planning. Patients could attend the ward round and this enabled patients to contribute to the planning of their care and individual recovery plan. Care plans were mainly written in clear and accessible language. However some care plans written in the first person when it was clear the patient would not have used the language recorded.
- Similarly on Kingston ward patients were involved in their care. Patients wrote on their care plans and had copies of them. When care plans were reviewed they also wrote comments. Patients felt involved in decisions about their care and treatment, including the type of medicines that were prescribed for them.
- On Richmond ward, there was less evidence of patient involvement in care plans. Some patients told us they had not been given a copy of their care plans. A recent ward nursing meeting highlighted that care plans should be shared with patients. This was so that patients could see what was written about them and care could be more collaborative.
- Hampton ward had monthly community meetings. These were attended by staff and patients and decisions were made about the arrangements for support on the ward. The minutes from these meetings were available and typed up. There was clear evidence of discussions, actions and issues being taken forward and resolved.

Good

Are services caring?

However, on Richmond ward, very few notes were taken during one community meeting we observed. The minutes of the meeting were a limited record of some of the patients' views. These minutes were not readily available to patients.

- Staff and managers listened to patients' suggestions. Patients were encouraged to submit suggestions in any format they wished. One patient had submitted a suggestion in pictorial format showing how the garden adjacent to Hampton ward could be improved.
- We spoke with five carers. Four of the five commented that staff were caring and interested in the well-being of their loved ones. However, one relative described how it was difficult to get information on the patients' progress.
- The hospital had recently carried out a survey of patients' views. The results showed that 77% of patients said they were likely or very likely to recommend the hospital to friends and family. However, although 61% of the patients felt that they were involved as much as they wanted to be in decisions about their needs and treatment, 39% of the patients did not feel that they were involved enough. Staff were taking steps to address the concerns raised by patients.
- A patient food survey had been carried out across the three wards in June and July 2015. Twenty four patients had completed the survey. Fifty six per cent of respondents felt they were sufficiently involved in menu planning.
- The provider had conducted a satisfaction survey of carers and relatives in 2014 but only two respondents were related to patients using The Huntercombe Hospital – Roehampton. It was therefore not possible to draw significant conclusions from the results. The hospital had adopted a new way of obtaining feedback from friends, family, carers and commissioners. This involved giving feedback via an application that could be downloaded onto an electronic device such as a tablet or some mobile phones. This was being rolled out for use.
- Patients knew about the independent mental health advocacy service. The advocate made regular visits to the wards. The independent advocate told us that staff encouraged patients to contact the advocacy service. Patients were made aware of the service when they were first admitted. There was information in reception about the advocacy service and the advocate attended the wards during the inspection.

Good

Are services responsive?

Our findings

Access and discharge

- There were no delayed discharges reported at the hospital for the six month period from December 2014 to May 2015.
- We received feedback about the service from 11 care co-ordinators and commissioners. They had mixed views about communication with the hospital and ward staff. One commissioner said communication with the service was good and ran smoothly. We received similar comments from some care co-coordinators who said staff were well-informed about patients and able to respond to queries. However, five care-co-ordinators said communication was poor. They raised particular concerns about the lack of information they received about discharge or transfer arrangements for patients.
- Bed occupancy rates on Hampton ward had varied between 63% and 77% from January to June 2015. Bed occupancy on the two PICUs was higher. On Richmond ward this varied between 82% and 96%. On Kingston ward bed occupancy ranged from 54% to 84%. There was usually a bed available for admissions at short notice.
- Integrated governance minutes showed the average length of stay in the PICUs was four to six weeks with a minimum stay of 10 days. On Richmond ward some patients had been on the ward for between three and six months. One patient had been on the ward seven years. At the time this patient had been originally admitted the ward had been a low secure rehabilitation ward. There had been a number of unsuccessful attempts to transfer the patient. Further plans were in place to transfer the patient to suitable alternative accommodation. One patient had been on Hampton ward for two years. The service had plans to transfer all patients with acquired brain injury to other suitable accommodation as there were plans to change the function of the ward.
- On Hampton ward admissions were planned and did not take place at the weekend and where possible not on a Friday. There was no waiting list for patients to be admitted.
- Once a referral to either of the PICUs was received, the wards aimed to provide a decision to the referrer within one hour. On some occasions, more information was required before a decision was made. The decision to admit a patient was made by the nurse in charge and ward doctor. Outside of normal working hours, the senior nurse for the hospital and the on-call doctor would decide. When the patient's circumstances were complex, the on-call consultant and on-call manager would be involved.
- On Hampton ward patient meetings were held prior to discharge. Discharge plans and summaries were produced in advance of a patient leaving the service. The majority of patients were discharged to the community.
- The majority of patients had been admitted to the wards from other parts of the country. They were a considerable distance from their home area. The hospital tried to facilitate visits from relatives and maintain contact. However, many patients we spoke with were unhappy with being far from home and their families.

The facilities promote recovery, comfort, dignity and confidentiality

- Hampton ward had a secure outdoor area and patients could access the garden during the day with support from staff. Patients on the PICUs had access to the garden every two hours during the day. The garden was shared between both wards. The wards took it in turns to access the garden.
- On Hampton ward there were rooms where patients could take part in activities including a kitchen. Gym equipment was available and could be used with support. The kitchen was locked and could only be used with a member of staff. This was not often used to enable patients to prepare their own meals, but there was a kitchen outside the ward where patients had opportunities to develop self-care skills.
- Kingston and Richmond wards had a range of rooms available, including rooms where activities could be undertaken. Visitors could meet patients in private. The dining room was away from the ward and meals were arranged so that patients from each ward would attend at different times.

Good

Are services responsive?

- Every ward had an activity programme for patients aimed at supporting their recovery. Activities took place both on and off the ward. These included cooking, tai chi and art. There was a gym and sports court. Patients had attended yoga, the library, swimming and the cinema. On Richmond ward, we observed two ward based activities taking place.
- In a patient food survey carried out across the three wards in June and July 2015 58% of patients did not think there were sufficient snacks available to them overnight. Seventy five per cent of the patients responding to the survey felt that there were not enough snack foods available to them outside of meal times and 40% thought there were not enough drinks available. However, 83% of patients said they enjoyed the meals. The survey report indicated that improvements were needed in all of these areas. During the inspection patients told us that the food was good and there was a choice of meals. Hot drinks were available at any time for patients, although they had to ask staff for these.
- There was no dedicated phone for patients on Kingston and Richmond wards. Patients needed to ask staff for a portable phone to contact their family. On Richmond ward, some patients waited a considerable time before they were able to get the phone. This was particularly the case when the ward was short staffed.

Meeting the needs of all people who use the service

- Patients' menus did not routinely include a halal option. Halal food could be requested. However, there was no confirmation that halal meals had been prepared according to religious requirements. We raised this with the provider during the inspection. They said they would address the situation immediately.
- A patient food survey was carried out across the three wards in June and July 2015. Twenty four patients completed the survey. Thirty six per cent of respondents said that, in relation to hospital meals, their religious and cultural needs were not being met and 38% felt that their special dietary requirements were not being met.
- Staff provided examples of when they had ensured patients received appropriate meals. For example, when a patient required kosher food the hospital had purchased particular food from a supermarket. During the inspection we noted that two patients were being provided with Polish foods, which reflected their cultural background
- The hospital had recently opened a "multi- faith" room where patients could worship should they wish. The room required some additional improvements to make it suitable for those who were Muslim to be able to pray facing east.
- The service had a holistic approach when considering patients' identities and staff gave examples of how they had supported a patient who was gay and wanted additional support from a community based lesbian, gay, bisexual and transgender (LGBT) group.
- Interpreters were available and were used to help assess patients' needs and to explain their rights, care and treatment.

Listening to and learning from concerns and complaints

- There had been six formal complaints made between June 2014 and May 2015. None of the complaints were upheld. Three complaints related to allegations that staff had used unwarranted physical force or were verbally abusive towards a patient. One related to an allegation that a social worker contacted a relative without the patient's consent. There was one complaint from a relative who was unhappy they had not been informed of a patient's admission to the hospital.
- Patients knew how to complain about the service. Posters explaining the complaints process were displayed on the wards. The information pack for patients contained a guide on how to make a complaint, compliment or comment. There was an easy read version of the guide available for patients so that everyone could use and understand the complaints process. The guide was given to all patients on admission.
- Staff recorded concerns and complaints and forwarded these to a senior manager. Patients were actively encouraged to complain. We saw an example of where a nurse had helped a patient to write and submit a complaint.
- There was a clear process in place to manage complaints effectively. All complaints were assigned to

an individual staff member to investigate the concerns raised. All complaints were formally acknowledged in writing within three days. The target for a final response to the complaint was within 25 working days. Staff explained any delays in completing the investigation or responding to the complaint to the patient in writing.

- Nine complaints had been recorded at the service between 1 April 2015 and 27 July 2015. Eight of the nine complaints had been completed within the target of 25 days. One complaint investigation was on-going. We reviewed the files of four complaints that had been received about the service between March 2015 and July 2015. The records showed that the complaints had been fully investigated and written responses had been sent to complainants. One record showed that staff had assisted a patient to make their complaint. Two complaint letters explained to patients how they could take the matter forward if they were unhappy with the response to their complaint. However, two letters failed to mention any further steps the complainant could take. In addition response letters to patients did not highlight the lessons learned by the service from the complaints or suggest that improvements would be made as a result.
- Audits of complaints were completed annually. The latest audit, dated July 2015, noted that there had been an increase in complaints submitted. This coincided with the implementation of improved training for staff on dealing with concerns and complaints and the introduction of a new complaints procedure. Key findings from complaints were reported to the integrated governance meeting so that learning could be used to improve care and treatment.
- Lessons learned from complaints and any themes identified were discussed at integrated governance meetings and shared with staff. Staff viewed complaints as a learning opportunity. Minutes of meetings showed that the outcomes of complaints were discussed within the ward teams.

Requires improvement

Are services well-led?

Our findings

Vision and values

- Most staff understood the values of the organisation and were committed and passionate about their work. Some staff knew the members of the provider's senior governance team and told us they had visited the hospital.

Good governance

- The hospital was going through a period of significant transition in terms of management. The registered manager had recently left and recruitment for a replacement was underway. An interim management team had been put in place by the provider. This team were running the hospital and implementing a number of improvements in the way the service was provided. The senior management team had not met for about a year prior to the arrival of the interim management team six weeks before the inspection.
- There was a structured governance system in place. A clinical improvement group (CIG) meeting took place on each ward. At this meeting staff discussed risk issues, audits, training and staff support. Senior managers told us that patients were involved in the clinical improvement groups, although we found no evidence of this. Ward community meeting minutes were discussed at the CIGs as a way of including patients' views.
- The CIGs, in turn, fed into the integrated governance meetings, chaired by senior managers. The research, audit and development group had oversight of a rolling programme of audits. The health, safety, risk and security group was chaired by a consultant psychiatrist and regularly reviewed the hospital risk register, security arrangements and general health and safety. These groups also provided information to the integrated governance meetings.
- Hospital staff conducted a number of regular audits as a way of monitoring the quality of care and treatment provided to patients. In June 2014 and May 2015 audits of records relating to patients care and treatment, called case note audits, were carried out across all three wards. In May 2015 a sample of 13 patient files were reviewed, seven from Richmond ward, four from Kingston ward and two from Hampton ward. The audit results showed that 63% of care plans either only partially met the standard required or did not meet the standard at all. There was no analysis in the report that identified how or why the majority of patient care plans were below standard. The report did not distinguish any differences between wards in terms of performance and did not identify the lack of personalised care plans we found on Richmond ward during the inspection, some of which dated back to 2014. Recommendations in the audit report included an action for ward managers to facilitate training in care planning for all ward nurses. However, there was no evidence that this had been followed up. There were no identified dates for completing the action. This showed that although standards of care planning had been assessed this had not led to an improvement in nursing practice.
- Similarly the audit reports identified shortfalls in multi-disciplinary assessments including risk assessments. In May 2015, 27% of the records reviewed during the case note audit only partially met or did not meet the standard required. This was a slight improvement on the results of the audit conducted in June 2014 when 33% of multi-disciplinary assessments had not met or only partially met the required standard. The audit report of May 2015 identified there had been a decrease in standards met in respect of multi-disciplinary risk assessments and initial psychiatric assessment in particular. The report recommended that the 'responsible clinicians must take a lead in scrutinising the risk assessment for accuracy and completion during the MDT ward rounds'. There was no named lead for this action or date by which it should be completed. During the inspection we found inconsistencies in risk assessments on Richmond ward. It was not clear how learning from the audit was used on the ward to make improvements or how closely this was monitored by senior hospital staff. Minutes of a CIG meeting held on Richmond ward on 14 July 2015 stated that all staff were to be trained in the new risk assessments. Training records showed that four nurses from Richmond ward had received formal training in how to complete the new risk assessment tool.
- The interim hospital manager reported that recommendations from audits were taken forward through ward CIG meetings and actions were reported back into the research, audit and development group. We reviewed the minutes of the last two CIG meetings

held on each ward. In the minutes of the Richmond ward CIG which took place on 12 May 2015 there was no record of who had attended the meeting. In reference to patient care plans it was reported that patients' 72 hour initial care plans had 'become too generic.' The action to address this was that ward managers would audit care plans on the ward. In the minutes of the next CIG meeting held on14 July 2015 showed that this was attended by the ward manager, clinical psychologist, lead occupational therapist and team secretary (minute taker). There was no record that care plan audits had been discussed and there was no further comment on 72 hour care plans. An action was recorded to 'update all care plans and evidence of patient engagement' in preparation for the CQC inspection. The CIG was not working effectively to support the improvement of patient care plans. The generic nature of care plans and lack of personalised patient care plans reflecting individual needs had not been identified or addressed.

- There was evidence of discussion of several clinical audits at the CIG meetings on Hampton ward. These included audits of infection control, consent to treatment, complaints, case notes and medicines management. However, there was less evidence of this in the PICU wards CIG meeting minutes. On Kingston ward the CIG minutes from July 2015 stated that a number of audits had taken place but there was very little learning from these highlighted in the minutes. On Richmond ward the CIG identified improvements were needed in medicines management. It was not clear how learning from audits was being used to make improvements on the PICUs.
- An external pharmacy carried out quarterly audits of medicines at the hospital. They reviewed prescriptions and medicine administration records. Two pharmacy audits had been completed in 2015. One covered the period from January to March 2015 and the second covered April to June 2015. The pharmacist activity report from January to March 2015 noted there had been 45 medicine administration errors in the time period. Thirty six of these had occurred on Richmond ward. Fifty eight per cent of the administration errors on Richmond ward related to staff failing to sign the medicine administration record or record the reason why a medicine was not given. In the second pharmacist activity report covering the period from April to June 2015 there had been a rise in the number of medicine administration errors to 48 incidents. Thirty six of these occurred on Richmond ward and 10 on Kingston ward. Of the 36 errors on Richmond ward, 28 related to missing staff signatures. This was an increase since the previous audit. Similarly the number of missing staff signatures on Kingston ward had risen from one missing signature in the first quarter of 2015 to nine missing signatures in the second quarter. Despite having identified a large number of medicines administration errors the service had failed to improve medicine recording practice on Richmond and Kingston wards. The monitoring of performance had not led to improvements.
- The service had not recorded information consistently. The number of incidents of restraints, seclusion and long-term segregation provided to us before the inspection was different from numbers of restraints, seclusion and long-term segregation recorded in the hospital's integrated governance meeting minutes between January and May 2015. The number of incidents recorded was much higher in the integrated governance meeting minutes. Senior managers explained this was due to a lack of agreed definitions of incidents and lack of consistency in reporting. It was hoped that the introduction of a new recording system would lead to improvement in the quality and reliability of management information. This could then be used to support improvements in quality and safety.
- The hospital was going through a period of considerable change. A new senior managerial team had been in place for six weeks. New systems of oversight, assessment and monitoring of care and treatment were being introduced. However, the systems and processes in place were not yet effective in ensuring the assessment and monitoring of quality and safety was robust. The analysis and evaluation of audit results and monitoring information was not sufficient to support effective improvements in service delivery across all wards.

Leadership, morale and staff engagement

- Staff sickness rates on the wards were low.
- Staff on the wards felt able to raise concerns. They described their managers as supportive. Staff were able to suggest improvements and some of these were acted upon.

Requires improvement

Are services well-led?

- Staff knew there was a whistle-blowing process and talked about what they would do if they had concerns they did not feel could be raised directly with senior managers. Staff could contact an external body, contracted by the provider, with concerns about the service if they did not feel able to raise the matter internally.
- The last staff satisfaction survey had taken place in September 2014. An action plan had been developed to address areas of concern raised by staff in the survey. Senior managers had begun to promote a "conversation into action" initiative, which encouraged staff to give feedback to the senior management team. A staff forum had been set up and staff were encouraged to make suggestions for improvements in the service. This aimed to improve staff engagement and improve job satisfaction.
- Nursing staff on Kingston and Hampton wards reported good morale. They felt empowered in their jobs, and satisfied with their roles. On Richmond ward, staff morale and feelings of job satisfaction was lower than the other wards.
- Leadership on Hampton and Kingston wards was particularly strong. Staff gave us consistently good feedback about the management team and the support that they received on these wards.
- Some staff had good understanding of duty of candour requirements. The provider had a policy in place called 'being open policy (incorporating duty of candour)' that supported staff in the implementation of the duty. Staff recognised that patients should be informed of a mistake and an apology offered. Senior staff provided examples of when this had happened and verbal apologies had been made.
- We found examples of good practice on all wards. However, good practice was not being shared across wards effectively.

Commitment to quality improvement and innovation

- Kingston ward staff were preparing for accreditation by the Royal College of Psychiatrists.

Outstanding practice and areas for improvement

Outstanding practice

- On Kingston ward, staff members had developed a booklet that recorded patients' attendance at, and level of engagement with activities.
- On Kingston ward, staff shared individual risk assessments with patients which enabled them to see a visual representation of their progress towards recovery.

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that there are always an appropriate number of skilled staff on Richmond ward to deliver safe, high quality care and treatment.
- The provider must ensure that staff are up to date with mandatory training requirements to ensure that they are competent to provide safe and effective care to patients.
- The provider must ensure that all staff, particularly on Richmond ward understand the risk management tool and are using it correctly and consistently. Staff must document clearly the reasons for changes in assessment of risk.
- The provider must ensure that patient care plans on Richmond ward are personalised and accurately reflect the individual needs and preferences of patients. Patients must be involved in developing their own care plans.
- The provider must ensure that when patients on Richmond ward are administered 'as required' medicines the reasons are made clear and documented in clinical notes.
- The provider must ensure that systems and processes used to assess and monitor standards of care, such as audits, are used to improve the quality and safety of the service.

Action the hospital SHOULD take to improve

- The provider should ensure that all patient bedrooms are safe, suitably maintained and clean, to promote patient recovery.
- The provider should ensure that policies for seclusion and long-term segregation are updated to reflect the current MHA Code of Practice.
- The provider should ensure all nursing staff on Richmond ward receive regular managerial and clinical supervision.
- The provider should ensure that staff fully understand mental capacity legislation and guidance, and are able to apply this to their practice.
- The provider should ensure that patients have easy access to nicotine replacement therapy and that this is actively promoted, in line with national guidance.
- The provider should ensure that the privacy and dignity of patients being taken into the de-escalation or seclusion rooms is maintained.
- The provider should ensure that there are enough snacks and drinks available for patients during the day and overnight.
- The provider should ensure that meals provided to meet patients' religious needs are prepared according to religious requirements.
- The provider should ensure that final response letters to complainants always include information about the options available if they are not satisfied with the outcome.

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 The care and treatment of service users did not always reflect their needs and preferences. On Richmond ward, most care plans for patients were generic and were not individualised or personalised to the patient. There was limited evidence of patient involvement or collaboration in care plans. This was a breach of regulation 9 (1)(b)(c)(3)(a)(b)(c)

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 Care and treatment provided to patients was not always appropriate and safe. Staff did not always assess risks to the health and safety of patients consistently. Consequently the provider could not be sure they were doing all that was reasonably practicable to mitigate any such risks. This was a breach of regulation 12 (1)(2)(a)(b)(c)

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 Systems and processes in place to assess, monitor and improve the quality and safety of services were not effective.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not deployed sufficient numbers of suitably qualified, skilled and experienced persons on Richmond ward at all times. Staff had not received appropriate training to enable them to carry out their duties safely and effectively. This was a breach of regulation 18 (1) and 18(2)(a)
	The service did not always keep accurate and complete records of the care and treatment provided to patients or decisions taken about their treatment. On Richmond ward, the reasons why patients received 'as required medicines were not always recorded. This was a breach of regulation 17(1)(a)(c)(f)