Milton Park Therapeutic Campus

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services well-led?	Requires improvement

Overall summary

We rated Milton Park Therapeutic Campus for safe and well-led as requires improvement because:

- Some units had high levels of new and inexperienced staff due to increased recruitment.
- The service had one functional seclusion room at the time of inspection on Cooper 1. This seclusion room did not meet the requirements of the Mental Health Act Code of Practice.
- Staff did not follow the National Institute for Health and Care Excellence guidelines for monitoring patients following administering medication.
- Some staff reported a lack of confidence in using oxygen in an emergency situation.
- Staff did not follow best practice for storage and disposal of sharps and medication.
- Clinics did not have examination couches. One patient reported having dressings changed in the corridor.
- Staff reported reduced numbers of cleaning staff and that clinical staff were responsible for daily cleaning of the units. Some units did not maintain up to date cleaning records.
- Managers did not provide staff with regular appraisals.

However:

Summary of findings

- The unit environments were clean and tidy and the furnishings in most areas were in good condition. There was a plan of works to update and modernise all unit areas.
- Staff updated risk assessments and care plans following incidents. Staff recorded incidents on the electronic recording system.
- Staff were aware of patients individual risk assessments and management plans.
- Mandatory training figures showed 86% of staff were up to date with their training.
- A new induction programme was in place for all new starters. There was specific induction process for agency staff.
- Managers had a programme in place to reduce blanket restrictions unless clinically indicated and individually care planned.
- There was a system in place for tracking and learning from incidents and other reportable events.
- Staff used recognised risk assessment and outcome tools to monitor patients' progress.
- Managers involved both staff and patients in workshops to agree the providers' new visions and values.
- There was a full programme of clinical audits completed by clinical staff and managers.

Summary of findings

Contents

Requires improvement

Milton Park Therapeutic Campus

Services we looked at
Wards for people with learning disabilities or autism.

Summary of this inspection

Background to Milton Park Therapeutic Campus

Milton Park Therapeutic Campus provides care, treatment and support for people on the autistic spectrum, and support with mental health concerns, anxieties, or learning disabilities.

The hospital has 11 units for people who require locked rehabilitation. At the time of inspection, two units, Gifford 1 and Gifford 2 were closed and unoccupied due to refurbishment. Nine units were open and there were 44 patients receiving care and treatment.

- Ashwood unit provides ten beds for women. This is a locked unit for people with autism, personality disorders, challenging behaviours. The unit is split over two floors and has an upstairs quiet annex.
- Elstow 1 unit provides five beds for women. This is a locked rehabilitation unit, but for more stable patients stepping down from Ashwood Unit.
- Elstow 2 unit provides six beds for younger men (18-25 years). This is a locked rehabilitation unit.
- Elstow 3 unit provides nine beds for men. This is a locked rehabilitation unit.
- Elstow 4 provides six beds for men. This is a locked rehabilitation unit.
- Elstow 5 provides six beds for men. This is a locked rehabilitation unit for more stable patients stepping down from Cooper 1, Elstow 3, and Elstow 4.
- Cooper 1 unit provides seven beds for men. This is a locked male intensive care and admission unit.
- Cooper 2 unit provides seven beds for men. This is locked unit for men with learning disability.
- Cooper 3 unit provides four beds for men. This is an intensive behaviour support unit for individuals with challenging behaviour who at the time are unable to live with others.

At the time of inspection, there was a registered manager and an accountable officer for controlled drugs in post.

Milton Park Therapeutic Campus registered with the CQC in 2005. The CQC carried out five inspections since 2010. Routine inspections were carried out in July 2011, September 2012, May 2013, and an inspection to check improvements in August 2013. The last comprehensive inspection was carried out in July and August 2015 with an overall rating of inadequate.

Our inspection team

The inspection team leader was Deborah Holder.

The team for this inspection consisted of two inspection managers, three CQC inspectors, a Mental Health Act reviewer, a specialist advisor, and an expert by experience.

The team would like to thank all those who met and spoke with them during the inspection.

Why we carried out this inspection

We carried out a focused announced inspection of Milton Park Therapeutic Campus to review the remedial actions taken by the provider in relation to the regulation breaches identified at the last inspection. The last comprehensive inspection was in August 2015. The report was published in May 2016. As this focused inspection took place within six months from the publication of the comprehensive inspection report, we have re-rated the safe and well-led domain.

The regulatory breaches related to

- The high use of agency and bank staff

Summary of this inspection

- Poor compliance to mandatory training and the level of training not being sufficient
- A lack of effective induction for agency and bank staff
- Poorly maintained and visibly dirty units
- The seclusion room on Cooper 1 was poorly maintained. The seclusion room on Elstow 1 did not meet the requirements of the Mental Health Act Code of Practice
- Potential ligature points found in some units that had not been appropriately mitigated
- Staff did not check resuscitation equipment or make sure this equipment was sufficiently available.
- We found some restrictive practices on Gifford B, Elstow 2 and Ashwood units. Long-term segregation was not used properly.
- The complaints system did not capture the lessons learnt or identify themes and trends. Staff told us that they did not receive feedback from complaints, or action taken as a result to improve the quality of care.
- The governance process was not robust.

At this inspection we found that:

- The use of agency and bank staff had reduced and averaged 15% of total staffing. There was a high level of new staff due to a recent recruitment drive. Some staff did not know the patients well and were inexperienced in care.
- Compliance with mandatory training had improved and was at 86%.
- There was an induction process available to all new staff including agency.
- Most unit areas were visibly clean and tidy and furniture was in good condition.
- There was one functional seclusion room on Cooper 1. This seclusion room did not meet the requirements of the Mental Health Act Code of Practice. Since inspection, the provider has confirmed that repairs have taken place.
- All units and gardens had potential ligature points however; ligature points had been identified and appropriately mitigated with the use of CCTV, nursing observation and risk assessments. There was a schedule of work planned across all the units to remedy areas of concerns across the environment.
- There were two emergency bags within the service located on Cooper 1 and Ashwood units.
- There was a governance process in place that looked at all areas affecting care and treatment, complaints and lessons learnt however unit based staff were not always aware of learning points arising from other units.

How we carried out this inspection

This was an announced focused inspection to look at safe and well led.

During the inspection visit, the inspection team:

- visited all nine units at the hospital, looked at the quality of the unit environment and observed how staff were caring for patients.
- spoke with 15 patients who were using the service and reviewed 18 comment cards.
- spoke with the registered manager and managers or acting managers for each of the units.
- spoke with 22 other staff members; including doctors, nurses, health care workers, catering and cleaning staff, administrators, and the visiting pharmacist.
- received feedback about the service from care co-ordinators or commissioners who worked with the hospital and the local safeguarding team.
- spoke with an independent advocate.
- attended and observed two hand-over meetings and observed one meal time.
- looked at 18 care and treatment records of patients.
- carried out clinic checks on 8 units.
- carried out a specific check of the medication management on nine units; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

Information about Milton Park Therapeutic Campus

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- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 15 patients who used the service. Overall, patients were positive about the care and treatment they received. They reported that staff were helpful and supportive. Patients described staff as caring and kind.

Some patients reported they would like more food, said some of the units were dirty, and there were delays in repairs to the unit environment.

Some patients reported issues with the manner that staff spoke to them and sometimes felt ignored.

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 had some staff vacancies. The provider relied on bank and agency staff to cover the roistering needs. Staff reported that some units had high levels of new and inexperienced staff. Patients reported that they did not always know the staff that cared for them.
- The service had one functional seclusion room at the time of inspection on Cooper 1. This seclusion room did not meet the requirements of the Mental Health Act Code of Practice.
- Not all staff knew where the resuscitation equipment was stored. Some staff reported a lack of confidence in using oxygen in an emergency.
- Staff did not follow best practice for storage and disposal of sharps and medication.
- The clinics did not have examination couches. One patient reported having dressings changed in the corridor.
- Staff reported reduced numbers of cleaning staff and that clinical staff were responsible for daily cleaning of the units. Not all units were maintaining up to date cleaning records. Some patients reported that the units were often dirty.

However:

- The unit environments were clean and tidy and the furnishings in most areas were in good condition. There was a plan of decoration works to update and modernise all unit areas.
- Staff updated risk assessments and care plans following incidents. Staff recorded incidents on the electronic recording system. Staff demonstrated understanding and knowledge of patient risks and associated management plans.
- Mandatory training was at 86%
- There was a new induction programme in place for all new starters including agency staff.
- Managers had a programme in place to reduce blanket restrictions unless clinically indicated and individually care planned.
- Emergency resuscitation equipment was available on two units.
- A practice nurse clinic room with examination couch was available on site for patients.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

Summary of this inspection

- The provider had reorganised its governance processes and begun to use quality information to inform performance, however this was in the initial stages and could not yet evidence sustained improvement in all areas.
- Leadership was not yet fully embedded at all levels. There was a gap in leadership at unit level. Lesson learnt and information sharing did not always filter down to ward-based staff. The staff model for qualified nurses meant that leadership was not visible on all units at all times.
- Staff did not follow National Institute for Health and Care Excellence guidelines for monitoring patients following administering medication.
- Managers did not complete regular appraisals of staff.

However

- There was a robust system in place for tracking and learning from incidents and other reportable events at management level via monthly meetings.
- Safeguarding's and other reportable incidences were reported to the safeguarding team and CQC. Internal investigations were taking place.
- Staff used recognised risk assessment and outcome tools to monitor patients' progress.
- Managers had involved both staff and patients in workshops to agree the services new visions and values.
- There was a full programme of clinical audits completed by clinical staff and managers.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement
Overall	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement

Requires improvement

Wards for people with learning disabilities or autism

Safe	Requires improvement
Well-led	Requires improvement

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- The layout of the buildings meant that all units had blind spots. Staff could not observe areas of the units at all times to keep patients safe. The managers had mitigated against this risk and promoted observation by installing CCTV and observation mirrors in all day areas and corridors. Staff would review footage as part of investigation processes and to establish events.
- There were ligature points in all units and gardens. A ligature point is a place to which patients' intent on self-harm could tie something to harm them. Managers completed ligature audits to identify ligature points throughout the units and there was a programme of work to address areas across all the units between October 2016 and February 2017. Managers mitigated risk by robust risk assessment and nursing observation.
- The unit complied with guidance on same sex accommodation, as there were separate units for male and female patients.
- The clinic room on Cooper 1 contained oxygen, the thermometer was visibly worn, and had plasters stuck to it. The clinic fridge temperature was recorded daily and in expected range, however, there was no record of defrosting or cleaning the fridge and frosting was seen on the back of fridge. Weekly checks of stock drugs and emergency equipment were taking place. The clinic held emergency drugs (epipen). Staff had checked the blood-monitoring machine but not the blood pressure machine and equipment required to do this was not available in the clinic. Staff managed the disposal of sharps appropriately, however staff did not manage disposal of medication well. We found bottles of wasted medication in the medication cupboard. Staff reported that the doom kit to dispose of medication was held by the practice nurse and not on the unit. We saw a sample signature list for doctors but not for nursing staff. There was no examination couch in the clinic.
- The clinic room on Cooper 2 was tidy and organised, daily temperature checks were completed and within expected range. Out of date medication was found in an unlocked cupboard that staff reported was used for training purposes. One medication had no opened/used by date recorded. There was no audit of cleaning or records that the clinic fridge has been defrosted. Frosting was present on the back of the fridge. The clinic held emergency drugs (epipen). The clinic contained a sharps bin sealed in July 2016. We saw a sample signature list for doctors and nursing staff. There was no evidence that blood monitoring and blood pressure machines were calibrated. There was no examination couch in the clinic.
- The clinic room on Cooper 3 was clean and tidy, room and fridge temperature checks had been completed. There was no record of defrosting or cleaning the fridge.
- The clinic room on Elstow 1 was clean and tidy however, there was a strong smell of drains. Staff did not routinely record daily room temperature. There was no record of defrosting or cleaning the fridge and frosting was seen on the back of fridge. The clinic held emergency drugs (epipen). Staff reported a lack of confidence in using oxygen should they need to. We saw a sample signature list for doctors but not for nursing staff. The sharps bin had no assembled date recorded and we saw that this was used to dispose of medicine (tablets). The lock on the clinic door was broken and there was no dispensing shelf or trolley. There was no examination couch in the clinic.
- The clinic room on Elstow 2 was clean and tidy. The clinic held an epipen however, staff on the unit did not know where the nearest emergency response bag was held. We saw medicine (cream) with no open or used by date recorded and the drug disposal bin did not have a date assembled recorded and was not being used appropriately. We found a bottle labelled "for

destruction" containing tablets in a cupboard. There was no audit trail for the medication in this bottle. Staff were observed signing for lunchtime medication at 3.30pm despite the medication being given earlier. The first aid box was low on some stock. Electric weighing scales had not been tested for electrical safety. There was no evidence to show if medical equipment had been calibrated.

- The clinic room on Elstow 3 was tidy and cupboards locked. Medication was stored in the fridge and labelled appropriately; clinic room and fridge temperatures were documented and within expected range. The clinic contained two sharp bins; one was full and locked but no date closed had been recorded, the second was opened but no assembly date was recorded. We saw evidence that weekly clinic checks were taking place. There was a bottle labelled " for destruction" which contained tablets. There was no audit trail for the medication in this bottle. We found two medicines where date opened had not been recorded. There was no examination couch in the clinic.
- The clinic room on Elstow 5 was tidy. The fridge and room temperatures were within expected range and daily temperatures were recorded. A sharps box was in use.
- The clinic room on Ashwood was tidy and well organised. Some staff reported that they did not feel competent in administering oxygen should the need arise. The unit followed procedures in the disposal of sharps. There was no evidence that the blood-monitoring machine had been checked or calibrated and the blood pressure cuffs were visibly dirty as was the aural thermometer. The unit had two scales for weighing patients however, there was no evidence of either being calibrated which could affect accurate recordings. There was no dispensing shelf or trolley and no examination couch in the clinic.
- Emergency response bags for the service were located on Cooper 1 and Ashwood unit. Some staff on other units told us that they did not know where the emergency bags were kept. We saw evidence that on occasions, response times to emergency situations were slow and some units did not respond to tests.
- There was one seclusion room in use during our inspection, located on Cooper 1. A clock displayed the time; the two-way communication system was in working order. There was a curtain track that was a potential ligature point, the bathroom doorframe was broken and had a sharp edge at the top that could be ripped off and fashioned as a weapon. There was poor line of sight from the entrance door to the ensuite bathroom. The entrance door was difficult to open and was sticking. The inside of the seclusion room could be viewed from the outside garden. The floor was carpeted and the flow of water from the ensuite shower made the floor wet. Since inspection, the provider has reported that they have carried out repairs to the seclusion room and fitted an additional convex mirror fitted to improve line of site.
- Most unit areas were clean and tidy although in some areas the decoration was dated. We checked cleaning rotas and found some gaps in daily recordings. Staff reported that on several units, there is no cleaning staff and health care assistants had taken over this responsibility. Staff reported that deep cleaning took place once a week. Some patients reported that the units are usually dirty.
- All units had notice boards with easy read leaflets on display.
- At the time of inspection, patients did not have access to the unit kitchens without staff supervision.
- Ashwood unit kitchen was visibly dirty in places; the microwave was rusted and pealing on the inside. The toaster has not been tested for safety. There was no hand soap available in the kitchen for hand hygiene.
- Cooper 1 unit was visibly clean and tidy. Unit staff reported they were responsible for cleaning the unit on a day-to-day basis.
- Cooper 2 recently had a new unit kitchen fitted, with the intention that patients would be able to access this kitchen under staff supervision to make drinks and snacks. The kitchen was clean and hand wash soap and towels were present. Cleaning records were seen and up to date. The fridge temperature reading was slightly high and this was reported to staff. There was a small room off the dining room used as a computer room; this room was unwelcoming and dark. The carpet in the lounge was loose at two doorways and presented a trip hazard, the sofas were old, and one sofa was a specialist sofa for use in a low stimulus environment. We observed three bedroom doors propped open on the unit.
- Elstow 1 had blind spots in the upstairs corridor; but the manager had mitigated other blind spots with mirrors. One patient was using an old seclusion room as their

bedroom; this room was unwelcoming and isolated from other areas of the unit. All other bedrooms were on the first floor. Bedrooms had been personalised. One bedroom observation window was broken and could not be closed from the inside. We observed one member of staff checking their personal mobile on several occasions.

- Elstow 2 had some blind spots and numerous ligatures points. A ligature risk assessment was seen and there was a plan of work scheduled for December 2016 to address areas of concern. The unit was clean and tidy with a welcoming lounge. The door to the quiet room was missing due to damage. A cleaning rota was seen.
- Elstow 3 recently had a new unit kitchen fitted and was clean but no fridge temperatures had been recorded. Not all bedrooms had anti ligature window fittings and in one bedroom; the encased blinds could not be opened as it was broken. There were no alarm call systems in the bedrooms. The communal bathroom contained several ligature points. There was no toilet paper available, and areas of the bathroom floor and wall required repair. There was a smell of damp in one bedroom and one patient reported that he did not like the choice of paint in his bedroom. Other bedrooms had been personalised and were well maintained. The self-contained flat on the unit had significant ligature points. Staff reported that a ligature risk assessment had taken place and reported that there were no risks on the unit.
- On Elstow 4 the kitchen fridge temperatures were routinely recorded; 94% of recordings were above the recommended temperature. A cleaning schedule was seen.
- On Elstow 5 the window lock in the day area was broken and could only be opened and closed from the outside. Staff reported patients are given £50 to personalise their bedrooms. Staff were unable to observe the bedroom corridor from the nursing office, and the unit mitigated this risk by having staff in the corridor at all times.
- Infection control processes were in place however, some units did not have hand washing soap or paper towels in areas such as kitchens and bathrooms. Anti-bacterial hand gel was in place on all units.
- All units had a response alarm system in place.

Safe staffing

- The provider had used a tool to establish staffing numbers. The staff establishment for qualified nurses was 17.7 whole time equivalent. There were 170.3 support workers at three different levels of seniority. Overall, there were 17 vacancies. Three service managers supported the nursing teams. We observed appropriate numbers of staff on the unit during inspection.
- We found that on some units staff were responsible for cleaning in addition to their clinical role. We saw evidence in unit meeting minutes that staff were struggling to complete all cleaning duties on some units and that unit cleanliness was described as poor.
- Some units had registered nurses working across two units. Staff told us that at times there was a heavy reliance on agency and bank staff.
- Overall, agency use between January and August 2016 averaged 15% of total staff. Staff reported that the use of bank and agency had reduced significantly on day shifts but remained high on nights on some units.
- Between January and August 2016 there were 23 shifts that were not covered by rostering staff however, these gaps were covered by redeploying floating staff and qualified nurses that are not within unit staffing numbers.
- Staff turnover rate was reported to be at 7 %.
- The provider had estimated safe staffing levels. Levels were established for each of the three staff hubs and reviewed weekly. Levels were set at one qualified nurse for every 10-12 patients during the day and 12-15 during the night. Support workers ratio was one staff to two patients. The provider also had additional “floating” staff that was available to provide cover across the service. There were three recovery workers in post to provide activities across the units.
- Some staff we spoke to did not fully understand processes around reporting incidents and restrictive intervention. One staff member reported that they relocate patients to their bedrooms, as they have no seclusion room.
- The service managers reported they are able to adjust staffing levels daily to take account of patient group and changes in patient presentation. The managers reported no resistance by senior managers to increase staffing when there was a need.
- Some patients reported that escorted leave and unit activities were cancelled due to insufficient staff numbers on occasions. Some patients reported that there are not enough staff on the units at all times and they do not feel safe with new staff.

Requires improvement

Wards for people with learning disabilities or autism

- The provider had a physical healthcare database that recorded all of the latest physical health checks for each patient including; yearly health check, bloods, optician, dentist, blood pressure, pulse, diabetes, epilepsy and asthma reviews.
- The safeguarding lead held the appropriate level of safeguarding training. The provider was reviewing safeguarding data on a monthly basis. Between March 2016 and July 2016 there were 301 recorded incidences, 27 met the provider's criteria for external notification to the local safeguarding team. Overall, 18 of the 27 incidents were allegations involving staff.
- Mandatory training figures showed 86% of staff were up to date with their training.

Assessing and managing risk to patients and staff

- Staff completed detailed risk assessment for patients on admission and reviewed them regularly to reflect change in risk. Most patients' risk assessments covered aspect of their health including medication, therapies, physical health, and activities. We looked at 18 care records and found the risk assessments had taken into account the patient's previous history as well as their current mental state, and were detailed.
- We found gaps in some of the unit's staff handover folders.
- From March 2016 to August 2016, there were nine episodes of seclusion. The providers audit evidenced compliance in most areas and an action plan was identified to address areas of concern such as continuous observation recording, medical review, and use of fluid charts.
- There were two patients in long-term segregation at the time of inspection. The provider had arrangements in place with commissioners to review these patients.
- Between March and August 2016 there had been 949 episodes of restraints with one prone restraint where a patient was turned to administer intramuscular medication. The highest levels of restraint were on Ashwood and Cooper 3. We saw evidence of the managers reviewing and monitoring themes and trends in the monthly meetings. In April 2016, the provider completed a detailed review of restraints and recommended a move to a new restraint technique; a programme of training is to start in October 2016 with an emphasis on positive behaviour support.
- There was a system in place for tracking and learning from safeguarding incidents. Management reviewed incidence monthly by looking at trends and themes however, this information was not filtering down to unit-based staff. The provider was reported all notifiable incidences to the CQC and safeguarding team.
- Staff used the Health of the Nation Outcome Scores (HoNOS) as a recognised risk assessment tool.
- The provider had a programme in place to reduce blanket restrictions. We observed that the doors to all gardens were open and patients reported that they could access the garden when they wished. There was a schedule of work for all unit kitchens, that when completed would provide patients with a safe area to make drinks and snacks for themselves under staff supervision.
- We found policies and procedures in place for use of observation.
- The rapid tranquilisation audit from December 2015 showed that the provider was not following NICE guidelines for monitoring patients following administering medication. Only 28.6% of monitoring forms were completed.
- Overall, 91% of staff had attended safeguarding level 1 and 85% level 2.
- There are safe procedures for children to visit the site with visits taking place in the centre. Not all staff were aware of child visiting procedures and some staff reported that children were not permitted on site.

Track record on safety

- There had been one serious incidence in last 12 months.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidences. The provider has an electronic reporting process and each unit had its own local risk register. Staff were able to describe what incidences needed reporting.
- The provider was reporting incidences to the CQC and the local safeguarding team appropriately.

Requires improvement

Wards for people with learning disabilities or autism

Are wards for people with learning disabilities or autism well-led?

Requires improvement

Vision and values

- Staff were aware of the organisations values. We saw evidence of staff and patients involvement in developing the provider's new visions and values via workshops and though feedback. Posters displaying the visions and values were in all areas.
- Unit staff were able to describe improvements and positive changes that had been implemented in the last 12 months.
- Staff knew who the most senior managers were. Staff told us that managers offered weekly meet and greet sessions to meet new and existing staff. We saw evidence of senior managers completing formal visits to the units.

Good governance

- We found that the provider had made some progress since inspected in 2015 in regards to improving the care and treatment provided to patients. The provider had an action plan in place that they were working towards to make improvements to the environment and strengthen management systems.
- The provider had reorganised its governance processes and begun to use quality information to inform and review performance, however this was in the initial stages for example, we saw evidence of fluctuating improvements in recruitment, cleanliness of units and supervision compliance. The provider is yet to evidence sustained improvements.
- Leadership was not fully embedded at all levels. There was a gap in leadership at unit level and qualified nurses was not visible on all units at all times. Senior management were aware of this gap and were in the process of reviewing the staffing structure at this level. Since inspection, the provider has confirmed that they have agreed a new structure and are recruiting a manager for each ward.
- There were processes in place for learning from incidences. Managers and senior managers were aware of incidences and lessons learnt across the service however, this did not always filter down to unit level. Service managers were not routinely attending clinical governance meetings and therefore this information was not always shared across the staff group.
- There were processes in place to capture systemic concerns via the clinical governance meeting. We saw evidence of a full agenda of topics being discussed and actions agreed however, implementation and sustained improvement was not always achieved. For example, the cleanliness and maintenance of some units were highlighted as a concern, yet we were informed that cleaning staff had reduced, and been redeployed to the kitchen to avoid use of agency.
- Regular morning meetings were held to discuss day-to-day issues across the units, review staffing needs, and discuss any concerns.
- Across the service, 86% of staff had received mandatory training. The provider had adopted a new training record system including e-learning modules that included competency tests. Topics covered by mandatory training were in line with skills for care and the provider had moved to annual refreshers for all staff. Staff told us that they were able to access some of this training from home and they were paid for training completed at home. Training in the Mental Health Act and Mental Capacity Act was three yearly however the provider was facilitating numerous workshops in-between to enhance and update learning.
- A two-week induction programme was in place with subsequent learning logs for new staff. All staff recruited since March 2015 had completed the care certificate.
- The provider was facilitating leadership training to staff at appropriate grades. The provider was supporting a number of health care workers to undertake their nurse training.
- Overall, supervision compliance was at 80% although this fluctuated between January and August 2016. Managers reviewed supervision compliance monthly. We reviewed individual supervision records, not all records had been signed by staff, and there was some duplication of records.
- Appraisal rates of staff between January and August 2016 was 2%. The provider had recently changed their

system to a rolling appraisal process meaning some staff would be 23 months since prior appraisal. The provider sent information following inspection, which evidenced an increase in appraisal completion to 40%.

- The staffing model did not allow all units to have a dedicated qualified nurse on shift. Staff on Elstow 1 told us that there could contact the nurse when they needed assistance and support.
- During inspection, we saw there was sufficient staff available to interact with patients on the unit and to facilitate off unit activities. The nurse in charge outlined staffs' responsibilities for each shift, including allocating staff to patients, for whom they would be responsible. We saw appropriate use of unit based administrators who were supporting clinical staff in tasks.
- Staff participated in clinical audits. There was a schedule of audits including all areas of patients case notes, Deprivation of Liberty Safeguards, rapid tranquilisation, infection control, patient leave, personal emergency evacuation plans, risk assessments medication, and environmental health and safety audits. Audits were reviewed by senior management in the monthly clinical governance meeting and had key performance indicators against them. We reviewed the minutes of these meetings and saw that issues had been discussed and action taken to make necessary changes and any risks were added to the risk register. During our inspection doctors reported that they do not lead on any audits however, we were provided with evidence following inspection that doctors had been involved in numerous audits.
- Between August 2015 and July 2016, there were 128 complaints, of which 49 were upheld following investigation. Management held monthly meetings and held a complaints panel to review themes and trends. There was evidence of staff learning from the outcome of complaints and service user feedback. Systems were in place to ensure actions from complaints are addressed and outcomes shared across the teams.
- Staff followed safeguarding procedures. There was a robust policy in place and the management team reviewed themes and trends monthly.
- The provider used key performance indicators and other tools to gauge performance of the unit teams.
- Service managers reported they had sufficient authority to make changes to staffing and increase staff when required. Service managers felt the senior management team was supportive.

Leadership, morale and staff engagement

- A staff survey was completed in March 2016. Overall 80.5% of feedback was positive and 84.5% would recommend Milton Park as place to work. We found unit teams were cohesive and individuals were enthusiastic about their job. Staff spoke positively about working at Milton Park and the processes and positive changes made within the last 12 months.
- Staff sickness rate was 9% over the last 12 months.
- Staff were given opportunities to expand their knowledge and develop their roles. For example, health care workers were supported to undertake a national vocational qualification level 3, which could lead to a secondment to complete a foundation degree, followed by undertaking a nursing degree. One unit manager had successfully been through this secondment process, starting work as a health care assistant.
- The provider had an induction process in place for agency and bank staff that involved a workbook and attendance on specific training. Overall 82% of non-permanent staff had completed this induction.
- The managers had put systems in place to support team working and staff support. Managers had identified that support for new staff was necessary for staff retention. New staff were offered support sessions and meetings with mentors and managers.
- Patients' contributed to a monthly newsletter. The provider also circulated a weekly communication newssheet.

Commitment to quality improvement and innovation

- The provider had registered with the Royal College of Psychiatry Accreditation for Inpatient Mental Health Services and was working towards achieving this accreditation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there is sufficient staff on the unit with experience and skills to meet the patient's needs.
- The provider must ensure that where patients' are secluded in their bedrooms then the seclusion process and policy is followed.
- The provider must ensure that seclusion rooms are fit for use and meet the requirements of the Mental Health Act Code of Practice.
- The provider must ensure that staff follow the NICE guidelines for monitoring patients physical health following administration of medication.
- The provider must ensure that staff are appropriately trained in the use of resuscitation equipment.
- The provider must ensure that staff follow best practice for storage and disposing of sharps and medication.
- The provider must ensure that there are adequate staff in post to keep the units clean and well maintained and that cleaning records are up to date.

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 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 Staffing.** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** • There was a high level of new and inexperienced staff on the units. • Staff and patients reported that there was not sufficient staff in post to keep the units clean and well maintained at all times. • Not all cleaning records are up to date.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 Premises and equipment.** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** • The seclusion room on Cooper 1 was poorly maintained, there was damage to the doorframe of the ensuite. There was no clear line of sight to observe the ensuite bathroom, and no CCTV. There

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Requirement notices

were privacy issues as the seclusion observation panel could be viewed from garden area. The seclusion suite did not meet the requirements of the Mental Health Act Code of Practice.

- This was a breach of Regulation 15(a) (e).

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Regulation 12 Medication **Regulation 12 The Health and Social Care Act 2008 (Regulated Activities) Regulations** • Staff did not consistently follow the NICE guidelines for monitoring patients following administration of medication. • Staff reported a lack of confidence in using oxygen in emergency situations. • Not all staff followed best practice for storage and disposing of sharps and medication.