Partnerships in Care Limited

The North London Clinic

Quality Report

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

Summary of findings

Ratings

Overall rating for this service	Outstanding ☆
Forensic/inpatient/secure wards	
Long stay/rehabilitation mental health wards for working age adults	

Summary of findings

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Overall summary

The North London Clinic is registered to provide the following regulated activities:

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

The hospital provides secure and rehabilitation services and has four wards:

Coleridge ward
Core service provided: forensic in-patient/secure wards

Male/female/mixed: male

Capacity: 17 beds - medium secure

Keats ward
Core service provided: forensic in-patient/secure wards

Male/female/mixed: male

Capacity: 15 beds - medium secure

Byron ward
Core service provided: forensic in-patient/secure wards

Male/female/mixed: male

Capacity: 10 beds - low secure

Tennyson House
Core service provided: long stay/rehabilitation

Male/female/mixed: male

Capacity: 19 beds

Mental Health Act responsibilities
At the time of the inspection all but one of the patients were detained under a section of the Mental Health Act 1983 (MHA).

The use of the MHA in the service was good. MHA documentation was generally compliant with the Act and Code of Practice.

Staff explained patients' rights to them in a way they understood and repeated this often. Patients had access to an independent mental health advocate who could support them.

Mental Capacity Act and Deprivation of Liberty Safeguards
Most staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, their understanding of the legislation and how it affected their everyday clinical practice varied. Some staff, particularly on Tennyson ward had a good understanding of the MCA and DoLS. Whereas some staff on the secure wards could not clearly explain the details of a mental capacity assessment and what a deprivation of liberty meant.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because:

Staff regularly checked the emergency equipment to make sure it worked properly and was easily accessible. Staff knew how to recognise and report safeguarding concerns. The wards were clean and generally well-maintained. Staff completed risk assessments and developed risk management plans to minimise risks to patients and staff. Detailed ligature risk assessments had been carried out on all wards and were regularly reviewed. Significant refurbishment work was taking place across the hospital to make the wards safer for patients. The refurbishment was being managed safely.

However, at night the hospital operated an on-call medical service and there was not always a doctor available on site. This may have caused a delay in responding to an emergency. The allergies section on the medicine administration records on Coleridge ward was not always completed so as to ensure patients were not put at risk of receiving unsuitable medicines. Some blanket restrictions had been reviewed and relaxed for some patients, following an individual risk assessment, although there were some in place on the secure wards. It was not always clear whether these were necessary for all patients. For example, patients on Coleridge ward could not access some parts of the ward in the evening and at night. Medical reviews of patients in seclusion did not always take place regularly at night. Records of seclusion were confusing and difficult to follow. Patients in the ground floor seclusion area in Coleridge ward had difficulty communicating with staff because there was no intercom.

Are services effective?

Outstanding

We rated effective as **outstanding** because:

Multi-disciplinary teams worked well together to care for and support patients. Comprehensive assessments of patients' needs were carried out on admission to the service and revised as needed. Care plans were in place to address patients' needs and risks identified and these were reviewed regularly. There was good oversight of patients' physical health. Staff received appropriate induction, training, supervision and appraisal. Staff followed best practice guidance when providing care and treatment. Care plans were evidence based and referenced the particular guidance that provided the rationale for therapeutic interventions. Patients had good access to psychological therapies. The service had good relationships with external agencies including excellent partnership working with the police. An individualised programme of activities

Summary of findings

was provided to patients on the wards based on their needs and interests. Maths and English tutors provided individual tutorials to help patients improve literacy and numeracy skills. The real work programme allowed patients opportunities to experience a real work situation and develop skills that would help them on their recovery journey.

However, although staff had received some training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards several staff we spoke with on the forensic inpatient/ secure wards did not understand how the legislation affected their day to day practice. There was a risk that staff would not always recognise the requirements of the MCA as it applied to individual patients. The hospital was planning to review smoking in 2016 in line with national guidance. Staff were not proactive in promoting alternatives to smoking, such as nicotine replacement therapy.

Are services caring?

Good

We rated caring as **good** because:

Staff were kind and compassionate and had a good understanding of patients' individual needs. Patients were involved in planning their care. They contributed to the development of hospital policies and decisions about improvements needed. Patient representatives met regularly with senior managers to express the views of patients on their ward and make suggestions for improvements. Patients' views were listened to and acted upon. The hospital held open days for carers to share information about the service.

However, minutes of community meetings were not kept where they could be easily found by patients so that they knew what had been discussed and any actions being taken.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

Ward staff were aware of the diverse needs of patients and made positive attempts to promote cultural needs. There was good discharge planning and very few delayed discharges. An individualised programme of activities was provided to patients on the wards based on their needs and interests. The service had a proactive approach to identifying patient concerns and complaints. Complaints were investigated and responded to within expected time limits. The hospital director apologised to patients when things had gone wrong

However, it was difficult for patients on Keats ward to make telephone calls in private.

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Are services well-led?

Outstanding 

We rated well-led as **outstanding** because:

Staff understood and shared the values of the organisation and were passionate about the work they did. The were clear governance structures in place which supported quality monitoring and assurance and facilitated improvements. Patients could contribute to the development of the service in a meaningful way. Senior managers were very responsive to feedback from patients and staff. There was a strong culture of patient involvement across the service which was driven by a committed multi-disciplinary team. Where shortfalls in the service were identified or negative feedback was received, improvement plans were put in place which were closely monitored until completed. The service learned lessons from incidents and complaints and used the learning to improve patient safety and experience. The culture of the service was open and transparent. There was excellent leadership at both ward and senior manager level and a culture of and commitment to continual improvement and innovation. In September 2014 the medium secure wards were reviewed by Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services, and scored 88% overall. The low secure ward scored 92%.

Summary of findings

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

Forensic inpatient/secure wards

The forensic inpatients/secure wards at The North London Clinic were safe, effective, caring, responsive and well-led. The wards had appropriate emergency equipment and this was checked regularly to make sure it worked properly. Medicines were managed safely. The wards were clean and well maintained. Refurbishment work was in progress aimed at making the environment safer for patients. Risks to patients were being managed effectively while the work was carried out. Individual risk assessments were completed for patients and regularly reviewed.

Multi-disciplinary teams worked well together to care for and support patients. Patients' needs were assessed and reviewed regularly and care plans were in place that addressed their needs. Staff received appropriate induction, training, supervision and appraisal. Staff followed best practice guidance when providing care and treatment. Patients had good access to psychological therapies. An individualised programme of activities was provided for patients on the wards.

Staff had a good understanding of patients. Patients were involved in developing their own care plans and in making changes in how the wards were run. Patients were encouraged to express their views in meetings with staff and contributed to the development of hospital policies and were involved in making decisions regarding improvements.

Staff were very aware of the diverse needs of patients and made positive attempts to promote and meet patients' cultural and religious needs. Discharges were planned and there were few delays in patients moving on.

Staff were committed to the values of the organisation although did not always feel connected to senior managers. There were good local governance processes that enabled managers and staff to identify where improvements were needed. Learning from incidents, complaints and safeguarding concerns was used to make improvements to the service. Some innovative and creative practice took place to help patients in their recovery and prepare them for more independent living.

However, at night the hospital operated an on-call medical service and there was not always doctor available on site to respond to urgent needs quickly. The allergies section on patients' medicine administration records on Coleridge ward was not always completed so as to ensure patients were not put at risk of receiving unsuitable medicines. Staff had received some training in the Mental Capacity Act 2005 but many staff we spoke with did not understand how the legislation affected their day to day practice. Minutes of community meetings were not kept where they could be easily seen by patients. It was difficult for patients on Keats ward to make telephone calls in private.

Long stay/rehabilitation mental health wards for working-age adults

The long stay/rehabilitation mental health wards for working-age adults were safe, effective, caring, responsive and well-led. Patients had up to date risk assessments and were involved in writing these. Actions were taken to minimise the risks to patients. Emergency equipment was accessible and being checked regularly by staff. There were enough staff to care for patients safely. Staff knew how to recognise different forms of abuse and how to report it in order to keep people safe.

Comprehensive and detailed assessments of patients' mental and physical health needs were carried out. Care plans were up to date, holistic and recovery orientated and addressed any needs identified. Patients received good physical health care and had access to a physical health nurse and GP when required. Staff received appropriate training, supervision and appraisal. Patients had good access to psychological therapies. The service had a strong multi-disciplinary team who worked very well together. Staff showed good understanding of the Mental Health Act

Summary of findings

1983 and the Mental Capacity Act 2005. Patients had their rights explained to them on a regular basis. There was a good range of group and individual activities available. Everyone had an individual activities and therapies timetable. Staff promoted community integration and social inclusion and supported patients to use local community facilities to support their recovery.

Staff were positive, kind and caring. Staff knew about the holistic care needs of individual patients and how best to work with them. Patients were routinely involved in their care planning, ward rounds and CPA reviews. Families and carers were welcome on the ward and involved in care planning and decision making. Patients were treated respectfully by staff.

The meals that were provided were of good quality. Many patients prepared their own meals, some with support from staff. Patients knew how to make a complaint and these were responded to appropriately. Patients and staff were actively encouraged to record all complaints, even minor ones, so that improvements could be made.

Staff understood and shared the values of the organisation. They were committed and passionate about the work they did. The ward was well-led. There was an open culture and staff felt able to raise any concerns they had. They were encouraged to put forward their ideas for improvements and share learning. There was clear a commitment to continual improvement.

Summary of findings

What people who use the location say

We spoke with 24 patients on all four wards, 18 on the forensic inpatient/secure wards and six patients in Tennyson House, the rehabilitation ward. We also received completed comment cards from 10 patients.

On Tennyson House the majority of patients told us they felt safe on the ward, liked the staff and felt involved in their care. They had been told about their rights and involved in planning their care and treatment. The majority of patients reported they received their medication at a regular time each day. They were able to stay in contact with families. Patients told us the food was good, but some thought there was a lack of choice. Patients were positive about the hospital's real work programme and the opportunities this provided. Some patients said the response from staff to concerns could be inconsistent. Many staff would listen and try to resolve problems although some seemed as though they did not want to listen.

About 70% of the patients on Coleridge, Keats and Byron wards, the three forensic/secure wards, who gave feedback, were positive about the support they received with their recovery. They said the staff listened to them and gave them encouragement to develop independence. They were positive about their experience in the hospital and felt that they received support that was appropriate to their needs. Most patients spoke of being involved in their care and support planning.

However, a minority of patients on the secure wards reported that occasionally staff were impolite. Patients said that some interactions with staff, particularly in ward rounds, tended to focus on incidents and when things had gone wrong, rather than on what had gone well.

We observed positive and caring interactions between staff and the patients, including during challenging situations. Discussions between patients and staff were held in private and away from other patients on the ward.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should review some of the blanket restrictions in place on the secure wards to see if they are required to manage the risks to all patients.
- The provider should ensure that medical reviews of patients in seclusion take place at the frequency required, particularly at night.
- The provider should ensure that episodes of seclusion are recorded clearly.
- The provider should ensure that any allergies that patients have are recorded on their medicine administration records.
- The provider should ensure that patients in the ground floor seclusion area in Coleridge ward can communicate easily with staff, for example, via an intercom.
- The provider should ensure that patients have easy access to nicotine replacement therapy and this is actively promoted in preparation for the planned review of smoking, in line with national guidance, in 2016.
- The provider should ensure that staff on the secure wards have a clear understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards and the implications for their practice.
- The provider should ensure that minutes from community meetings are displayed in areas of the wards where they can be easily seen by patients.
- The provider should ensure that patients can make telephone calls in private on Keats ward.

Summary of findings

Good practice

- The real work programme provided opportunities for patients to experience a real work situation. There were a range of roles that patients could apply for including acting as a ward representative (service user liaison), compound and grounds keeper, ward based cleaner and running the collapsible shop. A new role as vehicle maintenance assistant was being piloted in response to requests from patients. Patients were supported to develop skills in how to prepare for work including developing a CV and interview skills. They received appropriate training before they took up a particular role.
- The complaints process was very well managed. The patient safety and engagement lead was proactive in encouraging ward staff to record informal as well as formal complaints. She visited the wards every week to talk to patients about their experiences and raise any concerns they had.
- The hospital ran 'living together' groups on the wards. These brought together groups of patients to talk about how to improve their environment and experience in the hospital. Staff listened to patients and responded to suggestions. For example, on Keats ward patients had identified exercise DVDs and electronic games which could help them be more active. On Byron ward patients were closely involved in developing a phone use policy to accompany the introduction of mobile phones on to the wards.
- Maths and English tutors came into the hospital and provided individual tutorials to improve patients' literacy and numeracy skills.
- Patients were involved in the design and delivery of the service. There were a range of different ways in which patients could get involved and have their say. For example, each ward had a patient representative. A bi-monthly patient representative meeting took place and was chaired by the hospital director. A patient representative also attended part of the hospital's monthly security meeting. These groups provided opportunities for patients to have meaningful input into the way the service was run.
- The service had good relationships with external agencies including effective partnership working with the police. A police liaison officer held sessions on the wards aimed at helping patients feel safer.

The North London Clinic

Detailed findings

Services we looked at:
Forensic inpatient/secure wards; and Long stay/rehabilitation mental health wards for working age adults.

Our inspection team

Our inspection team was led by:

Team Leader: Judith Edwards, Care Quality Commission

The team that inspected the service consisted of ten people, an expert by experience, an inspection manager, four inspectors, a consultant psychiatrist, a senior nurse, a pharmacist inspector and a Mental Health Act Reviewer.

Background to The North London Clinic

The North London Clinic is provided by Partnerships in Care.

The service provides secure and rehabilitation services to male patients. It has 61 beds split over four wards. Keats Ward is a 15 bed medium secure ward; Coleridge Ward is a 17 bed medium secure ward and Byron ward is a 10 bed low secure ward. Tennyson House is a 19 bed supported recovery and rehabilitation service located in a separate building in the hospital grounds.

On the days of the inspection there were 57 patients at the hospital. All but one of the patients were detained under a section of the Mental Health Act, the other patient had been granted a conditional discharge from their section. Most patients had been at the hospital for less than two years. Many came from the London area but some came from further away.

We have inspected The North London Clinic six times since 2010 and reports of these inspections were published between March 2011 and March 2014. At the last inspection The North London Clinic was meeting essential standards, now known as fundamental standards.

Why we carried out this inspection

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

How we carried out this inspection

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:

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

Detailed findings

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 four wards of the hospital and looked at the quality of the ward environment;
- spoke with 24 patients on the wards;
- collected feedback from 10 patients using comment cards;
- spoke with the hospital director who was also the registered manager of the service;
- spoke with 33 staff working in the service, including senior managers, ward managers, doctors, nurses, health care support workers, social worker, psychologist, occupational therapists and administrator;
- looked at 18 care and treatment records of patients;
- observed how staff were caring for patients;
- carried out a specific check of medication management in the service;
- attended and observed two multi-disciplinary team meetings;
- carried out a Mental Health Act monitoring visit on Byron ward;
- received feedback about the service from 12 care-coordinators or commissioners;
- received information from one independent advocate;
- looked at a range of records, policies and documents relating to the running of the service.

Good

Is the service safe?

Our findings

Safe and clean environment

- It was difficult for staff on Keats and Byron wards to observe patients at all times because of the layout of the ward and corridors and poor sightlines. Risks were mitigated by staff walking around the areas several times an hour. CCTV and convex mirrors were being introduced to make it easier for staff to observe blind spots in communal parts of the wards. A policy was being developed jointly with patients to support the introduction of the CCTV cameras.
- The overall management of ligature risks and blind spots on the wards was categorised as 'amber', or medium risk, on the hospital risk register. Detailed ligature risk assessments had been carried out on all the wards and were reviewed monthly. There were plans were in place to manage the risks identified. Significant work was being undertaken to refurbish the wards and make the environment safer for patients. A two year phased programme to remove ligature points across the hospital was underway. High risk areas were being prioritised for improvements. The refurbishment plan included the installation of five ligature free rooms on Coleridge ward, two rooms on Keats and Byron and three rooms at Tennyson House. The refurbishment plan was detailed and showed that work would continue through 2015 and into 2016 across the hospital.
- There were ligature cutters available in all emergency 'grab' bags, on the walls in the nursing offices and close to isolated areas of the therapy corridor.
- Emergency equipment was checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Staff had received training in life support techniques and use of the automated external defibrillator to enable them to respond competently to emergencies.
- The seclusion rooms had sight of a clock and most had intercoms to enable communication between the staff and patient being nursed in the area. However, there was no intercom for the ground floor seclusion area. Staff told us that patients had to gain the attention of staff observing them to enable communication.
- Refurbishment work was taking place at the time of the inspection. This was being managed safely so that the security of the wards and patients was not compromised. Safety measures in place included checking tools into and out of the service. Temporary 'airlocks' had been constructed so that the safety of patients and workmen could be maintained and tools kept safe.
- The age of the building meant there were regular issues with maintenance. The service was recruiting additional maintenance staff to ensure that repairs could be addressed promptly. A detailed environmental audit of the wards had been carried out at the end of March 2015. This identified, for example, where furniture was missing or in need of repair, where rooms or fittings needed to be deep cleaned, and where flooring needed to be replaced. A plan was in place to track the progress of the actions that were needed. We saw that most of the actions were completed or in progress. Planned improvements included the refurbishment of all showers and toilets in the hospital.
- The wards were generally clean and clutter free. Cleaning audits showed that the cleanliness of the wards was monitored daily and areas needing attention were addressed promptly.
- An Infection control audit of the hospital was carried out every three months. The last one had been carried out in March 2015. An action plan had been put in place to address concerns identified by the audit. By the time of our visit most actions had been completed. The remaining actions required longer term work and were being monitored.
- A fire risk assessment had taken place and measures were in place to ensure the safe evacuation of patients and staff from the building in the event of a fire. Patients had personal emergency evacuation plans and this included a plan for any patient in seclusion.
- All staff carried a personal alarm on them at all times. Alarms alerted all staff in the hospital to an emergency situation. We observed staff including managers and members of the multi-disciplinary team responding promptly to alarm calls.

Good

Is the service safe?

Safe staffing

- The total number of whole time equivalent (WTE) substantive staff for the hospital was 132 (as at 1 March 2015). The total number of staff leaving in the previous 12 months was 36 WTE. The staff turnover in that time period was 27%.
- Staff vacancy rates were 12% at the beginning of March 2015. There were nine vacancies for qualified nurses across the service at the time of our inspection. Four new staff had been appointed and were undergoing employment checks before starting work. The experience of nurses was considered during recruitment in the context of overall skill mix on the wards. This ensured there were not too many inexperienced staff on the same ward.
- The overall staff sickness level at the beginning of February 2015 was 2%.
- Eighty shifts had been covered by 'bank' or agency staff in the three months prior to our inspection. During the three months there were three occasions when 'bank' or agency staff cover could not be obtained. On two of these occasions late notification of staff sickness meant cover could not be obtained in time and on one occasion the staff who arrived on the ward had not had appropriate training and was considered not safe to work. Regular 'bank' staff were used and some agency staff had been offered short term contracts to cover vacancies.
- Senior managers reviewed staffing levels across all four wards on a daily basis to ensure safe staffing levels were maintained. Coleridge ward usually had more staff than the agreed minimum in order to ensure that one to one close observations of patients could take place where needed, without compromising the safety of other patients. All ward managers told us they could adjust staffing levels and obtain more staff if patients' needs changed.
- The service had introduced two additional nursing shifts and a health care support worker from 9.00am-5.00pm to help support patients taking escorted leave in the grounds. This recognised that ward staff sometimes struggled to honour all escorted leave granted to patients without compromising the safety of patients remaining on the wards. Patient participation in activities was monitored weekly with the aim of offering patients a minimum of 25 hours of activities per week.
- Medical staff worked from Monday to Friday during office hours. There were three consultant psychiatrists present during the day. During the evenings and at weekends an associate specialist doctor was on-call, as well as a consultant psychiatrist and a sessional GP. There was not usually a doctor on site at night. Medical staffing levels were being reviewed to determine whether current levels were sufficient in light of changes in the MHA Code of Practice.
- We reviewed the personnel files of five staff working in the service. These 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. This included checks with the Disclosure and Barring Service and at least two references were obtained from previous employers. The service checked prospective employees' qualifications and professional registration. Job interview records noted any gaps in employment history and the reasons for these.
- Staff received appropriate mandatory training. More than 90% of permanent staff had completed the training required in 20 different areas. Completion rates ranged from 90% - 99%. There was an expectation that 'bank' staff completed the same mandatory training. Completion rates for 'bank' staff ranged from 83% - 100% in 19 areas. However, the completion rate for managing aggression and violence (MVA) training was 67% for 'bank staff'. Senior staff explained that three 'bank' staff required the MVA training. The staff who had not had training were identified in shift planning. This highlighted the skill mix and ensured sufficient suitably qualified staff were on duty during each shift. Staff who had not completed MVA training did not assist in restraining patients.

Assessing and managing risks to patients and staff

- We reviewed the risk assessments of 18 patients. Staff completed risk assessments of patients when they were

admitted to the wards. The assessment incorporated historical and known risk information. This information was used to develop risk management plans, which were reviewed regularly and updated after incidents.

- Byron ward had a positive risk-taking ethos, with less procedural and more relational security. There was a trial of patients having their mobile phones for set periods throughout the day. Patients used china plates and metal cutlery and had more access to their rooms than patients on the medium secure wards.
- Some blanket restrictions were in place on Coleridge ward. Patients on Coleridge were concerned that they could not access the main ward area during the evenings and at night. The layout of the ward meant that patients' bedrooms were upstairs and most communal areas downstairs. Staff managed the safety and security of patients by limiting access to the downstairs area during the evening and to the upstairs during the day. The hospital director told us the whole layout of the ward was being reviewed in order to see whether it could be changed to make it more accessible to patients at all times.
- Patients on Coleridge ward told us that they were only able to have a hot drink at four set times during the day. We raised this with the hospital director during the inspection. The service took action immediately to review the restriction. As a result the Coleridge ward manager agreed that staff would provide hot drinks to patients whenever they made a request. A hot drinks machine was about to installed as a replacement for a machine that had been broken recently. This would allow patients independent access to hot drinks.
- We found several examples of former blanket restrictions being reviewed and changed. For example, on Byron ward, there had been a blanket ban on patients having mobile phones. The practice had been reviewed recently and changes made. Four patients had been granted access to their mobile telephones following an individual risk assessment. Metal cutlery and crockery plates had also been introduced.
- There had been fifteen episodes of restraint of patients in the six month period to March 2015. Fourteen of these occurred on Coleridge ward. Three of the 14 restraints on Coleridge ward resulted in individuals being restrained in the prone or 'face down' position. The three patients had been given rapid tranquilisation whilst being restrained. Department of Health 2014 guidance states that "there must be no planned or intentional restraint in the prone position." More recent guidance has clarified that there may be exceptional circumstances where the use of prone restraint will happen.
- There were 16 incidents of seclusion and one incident of segregation in the six month period up to March 2015. There majority of these were on Coleridge ward, where there were 13 incidents of seclusion.
- The records relating to the seclusion of patients were in different documents and did not provide a clear record of medical and nursing reviews. This was not in accordance with the Code of Practice: Mental Health Act 1983 (CoP). There was no separate 'at a glance' record to ensure medical reviews took place at the correct times.
- We found that medical reviews of seclusion did not always take place as frequently as they should during the night. We reviewed records of three episodes of seclusion involving two different patients. The records showed that two hourly nursing checks had taken place as required through the seclusion periods. The records for one episode showed that medical reviews of the seclusion had been carried out every four hours. For the other two episodes of seclusion there had been two occasions where medical reviews had not been carried out four hourly during the night, as required. There was a gap of eight hours between medical reviews for one episode and a gap of nine hours and 15 minutes in the second episode. This put patients at risk of not having their needs reviewed appropriately whilst in seclusion.
- The provider was in the process of introducing a new seclusion policy which had been revised in line with the new MHA Code of Practice. This was implemented on 1 May 2015, the week after our inspection. The care of patients in seclusion and longer term segregation policy stated that patients in seclusion were to have face to face medical reviews every four hours, including during the night, until the first multi-disciplinary review took place and twice a day thereafter.
- Staff had received training in safeguarding vulnerable adults and had a clear understanding of safeguarding and the process for reporting concerns to the local

authority. Staff gave us examples of different safeguarding concerns that had involved patients on the wards and of safeguarding referrals that had been made.

- The pharmacist inspector carried out a specific check of medicines management on Coleridge ward and Tennyson House and reviewed the medicine administration records of most patients on those wards. Systems were in place to obtain, supply and administer medicines safely and as prescribed. A pharmacist visited the wards every week and audited records monthly. Ward managers audited medicines weekly to ensure they were being managed safely. There was a process for obtaining non-stock medicines out of hours from a local pharmacy. Emergency drugs were in date and checked regularly. There were daily checks on fridge temperatures to ensure medicines requiring cold storage were kept at the right temperature.
- Medicines were stored securely in locked cabinets. There was a locked container in place for a patient who was self-medicating in Tennyson House. All medicines were signed for when given. If medicines were not given, a code was recorded on the medicine chart explaining the reason for this. However, on Coleridge ward, staff had not recorded whether or not a patient had any allergies on five of 12 medicine administration records reviewed by the pharmacist inspector. As a result there was a risk that the safety of patients was not always being protected as important information for prescribing doctors was not available on the records.
- Regular blood tests were conducted for patients using certain medicines to ensure they were given the correct dose and to identify possible side-effects and risks to their health.
- There were rooms available in the hospital for patients to meet with families that included young children. Risk assessments were conducted before children were allowed to visit. The multi-disciplinary team ensured it was in the child's best interests to visit.

Track record on safety

- There were six serious incidents recorded in total from May 2014 to February 2015. The majority occurred on Keats Ward.
- Incidents on Keats Ward included a patient allegation of assault by staff and a patient found to have severe bruising to the upper and lower parts of body with no known reason or explanation for this. There were two incidents of patients going absent without leave from the hospital when on escorted leave, one on Keats ward and one on Coleridge ward. Another patient who was allowed escorted leave was given unescorted leave by mistake and was absent for 12 hours before returning to the ward.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and felt encouraged to do so. They gave examples of occasions when they had discussed incidents with the ward manager and completed the incident reporting tool.
- Senior managers discussed all incidents at a weekly meeting. Lessons learned from incidents were shared across the hospital. Staff provided several examples of improvements that had been made to the service as a result of learning from incidents.
- A patient had been held in long term segregation at the service for several months while waiting for a transfer to another hospital. The patient had been transferred out of the hospital two weeks before our inspection. The registered manager described how lessons had been learned from this. The area where the patient had been segregated was in the process of being refurbished as part of overall environmental improvements being carried out in the service. Greater consideration was being given to the comfort of patients who may have to be cared for in the area in future.
- The main commissioner of the secure services told us there was an open culture of reporting incidents, investigations and learning from these. Joint work had been done with commissioners to identify patterns and trends in incidents but none had been found.
- Staff were offered a debrief after any serious incidents. Reflective practice sessions took place on each ward to enable staff to discuss incidents in a group setting.

Outstanding ☆

Is the service effective?

Our findings

Assessment of needs and planning of care

- We reviewed the care records of 18 patients. All patients had received a comprehensive assessment on admission. This included an assessment of their physical health.
- Care plans were person centred, individualised, recovery oriented and addressed patients' needs and goals. They were regularly reviewed and updated. Where a physical health need had been identified, care plans had been implemented to ensure they were addressed. Staff carried out routine physical health monitoring. Each patient had an annual physical health check.
- The service used an electronic recording system for storing patients' records. This was available to staff when needed and we observed staff completing contemporaneous notes. Records were updated during multi-disciplinary team meetings. Access to the electronic records system required a personal card and password log in which helped ensure records remained confidential.

Best practice in treatment and care

- We saw that staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions. Patient care plans were evidence based and referenced specific NICE guidelines, provider policies and best practice. The psychological therapies provided were in accordance with those recommended by NICE. They included mentalization based therapy and group work with patients with sexual offending behaviour.
- Patients had access to psychological therapies when they needed them. The service reported an actual mean time of 5 days from referral to initial assessment, for psychological therapies and 25 days from initial assessment to onset of psychological treatment.
- Patients' physical health care was well managed. A full time physical health nurse had been employed to ensure patients' physical health care needs were met.
- The hospital was planning to review smoking on the site in 2016 in line with national guidance. Two staff had been trained as smoking cessation officers. However, we saw little evidence that patients were actively supported to stop or reduce smoking although nicotine replacement therapy was available on request.
- 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. This was redone every six months.
- The wards used a number of measures to monitor the quality of the service provided. A range of audits were conducted on a weekly or monthly basis. These included audits of care plans, medicines, explanation of patients' rights and physical health checks.
- The hospital had a recovery approach to supporting patients. From Monday to Friday there was a wide range of therapeutic activities available on an individual and group basis on the wards and in the recovery centre in the main hospital. At the weekend there were less structured activities and these were provided mainly by the nursing staff. The therapeutic programme on offer was reviewed every 12 weeks. However, if an activity was clearly unpopular this could be changed or modified before the 12 weeks review.
- Maths and English tutors came into the service and provided individual tutorials to improve patients' literacy and numeracy skills.
- Patients were able to apply for a paid job in the service through the real work programme. An employment skills group helped patients develop a CV, learn interview skills, take part in a mock interview and reflect on their strengths and approach. This helped patients secure a position in the real work programme. The occupational therapist led community integration groups for patients and encouraged them to use local facilities such as the leisure centre.
- There were opportunities for patients to self-medicate and learn to manage their own medicines as they approached discharge. Two patients on Tennyson House were self-medicating. There was a self-medication protocol in place to make sure this was managed safely. However, staff could not find completed self-medication contracts for the two patients.
- We received written feedback from an independent advocate who visited patients in the hospital. They reported that the service provided support to patients

to develop practical independent living skills as well as self-development and reflection groups. They considered the various groups, along with the real work programme worked very well.

Skilled staff to deliver care

- Care and treatment was delivered by a team of multi-disciplinary professionals. These included nurses, health care support workers, occupational therapists, social workers, psychiatrists and psychologists.
- Staff received appropriate training, appraisal and professional development.
- Between 76-100% of staff on the four wards had received an annual appraisal. Of the remaining eight staff who had not had an appraisal seven staff were new to the organisation.
- All doctors employed in the service had undergone professional revalidation in the last year.
- Minutes of the senior management team regional meeting dated 27 January 2015 stated that nursing supervision completion rates were at 90%, with an average of 80% across other departments.
- New staff, including bank and agency staff, completed a period of induction before taking up their full responsibilities on the ward. This ensured that all staff working on the wards were fully trained and familiar with ward routines and hospital policies.
- Some staff had undertaken training in addition to mandatory training such as motivational interviewing and behavioural activation which they had been able to use in their day to day work. A health care support worker told us they had been supported to pursue an access to nursing course by the hospital and was now applying to train as a nurse.

Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary team (MDT) meetings on all of the wards. The different professionals worked together effectively to assess and plan patients' care and treatment. The MDT meetings and ward rounds were well attended and the holistic needs of patients were discussed. Patients attended the meetings and were able to discuss and ask questions about their care and treatment. Excellent MDT working was evident in meeting records, care records and interviews with staff and patients.
- Regular handovers took place between shifts enabling effective sharing of essential information. We observed a handover discussion. Staff handed over important information about patients including changes in medication and risks.
- The MDT worked closely with external agencies such as drug and alcohol services and the local police. They worked with housing and volunteering organisations in arranging support for patients being discharged from hospital.
- The service worked effectively with commissioners and community mental health teams. We received feedback about the service from 12 care co-ordinators and commissioners. They described good working relationships with the service and staff.

Adherence to the MHA and MHA Code of Practice

- Ninety seven per cent of staff had received training in the Mental Health Act 1983 (MHA). Staff had a good understanding of the MHA and associated Code of Practice.
- A Mental Health Act Reviewer carried out a review of the use of the Mental Health Act on Byron ward.
- The use of the Mental Health Act (MHA) in the service was mostly good. MHA documentation was filled in correctly, was up to date and stored appropriately. Regular audits were carried out on each ward to ensure the MHA was being implemented correctly.
- Patients' rights were explained to them by staff in a way they could understand. This was repeated at regular intervals. The majority of patients we spoke with remembered being told about their rights.
- A standard 'consent to treatment' form was completed for all patients whose files we reviewed.
- One patient was being treated under the authority of a form T2 prior to their transfer to Byron ward. At the time of their transfer there was a permanent change in the approved clinician in charge of their treatment. We were unable to locate evidence that a new T2 form had been completed for approximately five months following their

transfer to Byron ward. Where there is a permanent change in the approved clinician in charge of the patient's treatment a new certificate should be obtained. This was discussed with staff during the visit and action was taken to address the omission.

- Patients had access to an Independent Mental Health Advocate (IMHA) and general advocacy services. Patients and staff knew how to access IMHA services. The advocate provided written feedback about the service to us. They said that staff could be more proactive in ensuring patients in seclusion were able to access advocacy and suggested more information about the advocacy service could be displayed on the wards.

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).
- Training on the MCA and DoLS was part of the Mental Health Act training provided to all clinical staff. Ninety seven per cent of staff had completed this training. Some additional training in MCA had been provided to staff on Tennyson. When we spoke with staff on the wards it was clear that Tennyson House staff had a much better understanding of MCA and how it affected their day to day practice. This reflected the additional training they had received. Staff on the secure wards had generally poor understanding of MCA and DoLS and implications for their work.
- On Tennyson ward in particular there was good recording of discussions in patients' notes regarding their capacity and assessments of capacity. Where staff had concerns about a patient's behaviour and decision making the patient's capacity had been assessed and recorded.

Is the service caring?

Our findings

Kindness, dignity, respect and support

- Staff on all wards were kind and caring and respected the privacy and dignity of patients.
- About 70% of the patients we received feedback from were positive about the support they received from staff. They said the staff listened to them and gave them encouragement to develop independence in their lives. However, other patients were less positive and considered that some staff were impolite. Patients said that some interactions with staff, particularly in ward rounds, were focussed on incidents and what had gone wrong rather than giving feedback about where things had gone well and the patient was making progress.
- Staff knew the patients and their needs very well. This was demonstrated in multi-disciplinary team meetings we observed and in individual discussions with staff. Staff had good knowledge of patients and triggers to negative behaviours. They worked as a team to support patients and de-escalate situations to promote a safe environment.

The involvement of people in the care they receive

- When patients were admitted to the wards they were shown around and given a buddy who was another patient on the ward. The buddy helped orientate them and introduced them to staff and patients. The occupational therapist at Tennyson House provided new patients with a leaflet explaining the role of occupational therapy.
- Patients were actively involved in care planning and risk assessments. Most patients had copies of their care plans. Care plans were written in clear and accessible language. During the MDT meeting we observed patients were encouraged to express their views. Where they were not happy about the decisions made, these were discussed and the reasons for actions were explained.
- Patients were involved in the design and development of the service. They had been involved in choosing new art work and furniture as part of the refurbishment of the hospital and wards which was taking place.
- Patients had chosen to spend money, awarded to the hospital by a new parent company, on a new woodwork shop.
- The activity programme was reviewed regularly and patients were encouraged to give feedback on what they did and did not like. Changes were made to the programme in response to this.
- The hospital ran 'living together' groups on the wards. These brought together groups of patients to talk about how to improve their environment and experience in the hospital. Patients who shared flats in Tennyson House were encouraged to meet in 'living together' groups and discuss how they lived together and shared tasks including keeping communal lounges and kitchens clean.
- There were several patient representation group meetings and meetings at which patients were represented. For example, a service user liaison meeting took place weekly and was chaired by an occupational therapist. Each ward had a patient representative. A bi-monthly patient representative meeting was chaired by the hospital director. A patient representative also attended part of the hospital's monthly security meeting. These groups provided opportunities for patients to have meaningful input into the way the service was run.
- The hospital involved carers where possible. Carers days had been held. At Christmas nine carers had attended a Christmas lunch. Another carers day was due to be held on the Saturday after our visit to the service. A Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services report for Byron ward in September 2014 praised the use of slide shows at family and friends meetings.
- The wards had weekly community meetings for patients and staff to discuss the general running of the wards and make decisions about the arrangements for the week ahead. In all wards the minutes of the meetings were brief and kept in the staff office areas, so were not readily accessible for patients to read what had been discussed.

Is the service caring?

- Patients were involved in the development of hospital policies such as the policy covering the use of CCTV monitoring. Patients on Byron ward had been involved in deciding how the introduction of mobile phones on to the ward could be safely managed.
- A patient satisfaction survey had been completed by the service in March 2014. In response to the feedback from patients an action plan had been put in place to address the concerns raised. For example, 26% of respondents said they felt unsafe on the wards. The hospital had set up police liaison meetings on the wards and appointed a patient safety lead to reassure patients and increase confidence.
- In the satisfaction survey some patients had rated the food provided as poor and said they were not always able to get a specific diet. In response to this a new chef had been employed and they attended meetings with patients on a regular basis to discuss the quality of meals. Patients we spoke with during the inspection told us the standard of meals had improved. A full time physical health nurse had been employed to ensure patients' physical health care needs were met following requests from patients for better health care.

Good

Is the service responsive?

Our findings

Access and discharge

- There were two delayed discharges reported in the six month period between October 2014 and March 2015. These were on Coleridge ward and Tennyson House. The patient on Coleridge ward was discharged six weeks later than planned. The patient on Tennyson House was discharged two months later than planned.
- Senior management team meeting minutes in January 2015 reported that bed occupancy was steady with 58 patients receiving care at the hospital, which has 61 beds.
- The hospital tried to offer an integrated pathway for patients so that they were able to progress from a more secure to a less secure environment and then to the rehabilitation ward, Tennyson House. However, this was often dependent on commissioning decisions. Secure services were commissioned by NHS England whereas rehabilitation beds were commissioned by clinical commissioning groups.
- The hospital had a good relationship with commissioners. The commissioner of the secure services reported a good relationship with the hospital director and good patient involvement and outcomes for patients.
- We received feedback about the service from 12 care co-ordinators and commissioners. They described good working relationships with the service and staff and particularly the hospital director. Six respondents specifically mentioned having good communication with the service.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had a number of rooms for use, including lounges, dining rooms and clinic rooms. Tennyson House had good facilities, including areas for activities, therapies and kitchens that were used by patients.
- There was equipment available to support patients to occupy their time, such as games consoles, books and board games. Within the hospital patients could access the faith room, library, gym and games room by arrangement with their clinical team.
- Patients were positive about the food and meals provided at the hospital. Snacks were available outside of mealtimes, such as fruit and biscuits and toast could be prepared on request. The occupational therapist supported patients to develop their cooking skills. On Tennyson House several patients who lived in communal flats in the unit shopped for and prepared their own meals.
- Patients were able to personalise their bedrooms with their own belongings, such as posters, wall coverings and a television. Patients were able to securely store their possessions in their bedrooms.
- From Monday to Friday there was a wide range of therapeutic activities available on an individual and group basis on the wards and in the recovery centre in the main hospital. At the weekend there were less structured activities and these were provided mainly by the nursing staff. The therapeutic programme on offer was reviewed every 12 weeks. However, if an activity was clearly unpopular this could be changed or modified before the 12 weeks review.

Meeting the needs of all people who use the service

- The North London Clinic patient satisfaction survey data for March 2014 showed that 70% of patients who responded rated the provider “good”, “very good” or “excellent” to the question “overall, how would you rate the care you are receiving from us?” Twenty two per cent of patients rated the provider as "fair."
- The hospital wards were not easily accessible to patients with mobility needs due to the nature of the building. Tennyson House had some bedrooms on the ground floor which were accessible.
- Staff received training in equality and diversity as part of their mandatory training. Patients and staff had access to interpreters to support patients at meetings about their care and treatment. Staff provided examples of when an interpreter had attended ward rounds and key meetings with a non-English speaking patient. There were information leaflets for patients which were available in different languages if required.
- Individual needs were assessed, such as in relation to cultural and religious needs and any particular dietary needs were accommodated.

Good

Is the service responsive?

- Some local faith representatives visited patients on the wards, whilst others could be contacted to request a visit. Patients, who wished, were escorted to local places of worship, dependent upon their leave entitlement.

Listening to and learning from concerns and complaints

- There had been 28 formal complaints made between March 2014 and February 2015, most of which related to Tennyson House. Only three of the 28 complaints were upheld and four partially upheld. Two of the upheld complaints were on Tennyson ward and one on Keats ward.
- The seven complaints that were either upheld or partially upheld related to the attitude of staff, delayed discharge, legal matters (including access to records, and consent to treatment), and patient leave.
- Patients we spoke with said they knew how to raise a complaint, or would discuss any concerns with the ward manager. Information on how to make a complaint was displayed in the wards. An easy read version of the complaints leaflet had been developed which helped patients understand the procedure.
- The patient safety and engagement lead for the hospital was actively engaged in raising awareness of the complaints process among patients. She visited all the wards every week to hold a 'drop-in' for patients to discuss concerns and complaints. She encouraged staff to record all complaints including informal complaints. This had led to an increase in the number of informal complaints recorded from four or five informal complaints per month to 14 or 15 currently.
- The service had a policy of responding to all formal complaints with 25 days. A letter acknowledging a complaint was sent within 48 hours. If the investigation of a complaint was delayed for any reason a written explanation was provided to the complainant. The ward to board report for March 2015 showed that nearly all complaints were responded to within 25 days. Between July 2014 and March 2015 there had been 24 formal complaints and 22 of these had been responded to within the expected timescale.
- All investigations were carried out by staff trained in conducting an investigation. There were currently seven multi-disciplinary staff who were trained which meant investigations could be carried out promptly. Investigation reports identified learning outcomes and made recommendations for improvements.
- All complaint responses were reviewed by the hospital director before they were sent to patients in order to ensure they were of good quality.
- If complainants were unhappy with the outcome of their complaint they could raise the complaint at the second stage with the provider. We reviewed three complaint files and saw that all the response letters explained to patients how they could take the complaint further if they wished.
- Complaints were overseen by the regional complaints officer who visited the service every monthly.
- There were plans in place to analyse complaints more thoroughly in order to identify trends. Information on complaints was fed up through the monthly clinical governance meeting.
- The patient safety and engagement lead audited complaints books on each ward every month.

Outstanding ☆

Is the service well-led?

Our findings

Vision and values

- Staff knew about and understood the values of the organisation, which were valuing people, caring safely, integrity, working together and quality. They were passionate about the work they did. We saw examples of the values being put into practice throughout the hospital.
- Staff performance appraisals were linked to the organisational values.
- Staff said they were well supported by their peers and ward managers. However, the some staff on the secure wards spoke of not feeling connected with senior managers within the hospital and felt they did not understand the pressures of their work. This reflected the findings from the 2014 Partnerships in Care staff survey, which found that staff did not always feel valued.
- However, on Tennyson House staff knew the names of senior staff in the organisation, said they had visited the ward and felt they had opportunities to raise issues with senior managers.
- Senior managers had recently held a drop in where staff could go to ask questions or raise any concerns with them. Staff told us they had attended and found this useful.

Good governance

- The were clear governance structures in place which supported quality monitoring and assurance and enabled oversight of the hospital services .The hospital senior management team met monthly and involved all heads of department. The medical advisory committee met monthly.
- Ward to board performance dashboards had been developed to support managers to monitor standards of care and the performance of the staff team.
- The service was very responsive to feedback from patients and offered meaningful opportunities to significantly influence service design and delivery.. There was a strong culture of patient involvement across the service which was driven by a committed multi-disciplinary team.
- Where shortfalls in the service were identified or negative feedback was received, improvement plans were put in place which were closely monitored until they were completed.
- The service learned lessons from incidents and complaints and used the learning to improve patient safety and experience. There were clear channels for reporting incidents and escalating risk information. Learning from incidents and complaints was disseminated to staff and led to improvements in care.
- Staff and managers listened to patients and made great efforts to involve them in all aspects of the service. The patient safety and engagement lead was proactive in encouraging ward staff to record all informal complaints so that staff and senior managers could learn from them.
- Staff participated actively in clinical audits on all the wards in order to monitor standards of care and check that hospital policies and procedures were being followed. Where shortfalls were identified action was taken to address the concerns. Action plans were reviewed regularly to ensure agreed actions were completed.
- Staff had completed mandatory training and were able to access additional training courses. Staff had received the training they needed to care for people safely. All staff had received an annual performance appraisal and supervision normally took place as planned.
- There were sufficient well trained staff on duty to ensure that patients could be cared for safely and effectively. Additional staff could be obtained if the needs of patients changed.

Leadership, morale and staff engagement

- The culture of the service was open and transparent. There was excellent leadership at both ward and senior manager level and a culture of and commitment to continual improvement and innovation.
- Ward managers were visible on the wards, were accessible to patients and provided support and guidance to staff.
- Staff were aware of whistle-blowing processes and felt able to report concerns and suggest improvements needed within the hospital. They were confident they would be listened to by managers. Staff felt encouraged to bring forward ideas for improving the service patients received.

Outstanding ☆

Is the service well-led?

- The hospital staff survey from 2014 showed declining staff satisfaction over the last 2 years. The survey identified staff concerns about pay, work pressures and not feeling valued. An action plan had been put in place to respond to the concerns.
- The hospital had introduced a quarterly staff consultation committee which was working actively to address the concerns of staff. The hospital was considering how it could better reward staff and increase pay bandings to address concerns about lack of progression. Employee benefits such as vouchers for childcare and shopping were in place and benefits for 2015/16 were being reviewed.
- Senior managers had recently held a drop-in for staff. Eleven staff had attended the drop-in and gave feedback on their experiences of working at the hospital.
- A leadership and development training programme was being rolled out for staff.
- The hospital director was open and transparent in his approach to running the service. A new policy had been developed by the provider to support staff and managers in the implementation of the duty of candour requirements. The policy was due to be implemented on 1 May 2015. The manager described an open culture in the organisation. He provided an example of a written apology given to a patient following a mistake by staff which had resulted in the suspension of the patient's leave.

Commitment to quality improvement and innovation

- The real work programme offered patients the chance to apply for paid job roles in the service. Jobs were advertised, patients completed application forms and were interviewed. Patients could take part in workshops to help them develop their curriculum vitae and take part in a mock interview in preparation for applying to the real work programme. Roles included acting as a ward representative (service user liaison), compound and grounds keeper, ward based cleaner and running the 'collapsible' shop. Twelve roles were offered every quarter. A new role as vehicle maintenance assistant was being piloted. This role had been suggested by patients. All patients involved in the real work programme received training in manual handling, health and safety and food hygiene, where appropriate.
- The service had established a positive working relationship with the local police liaison officer. The officer had attended the patient representatives meeting in January 2015 and held monthly surgeries for patients on the wards. They met regularly with senior staff to review any concerns and incidents. It was hoped this initiative would increase patients' confidence and help them feel safer.
- The hospital ran 'living together' groups on the wards. These brought together groups of patients to talk about how to improve their environment and experience in the hospital. Staff had listened to patients and responded to what they said. For example, on Keats ward patients had identified exercise DVDs and electronic games which could help them be more active. On Byron ward patients were closely involved in developing a phone use policy to accompany the introduction of mobile phones on to the wards following the relaxation of a blanket ban on mobile phones.
- In September 2014 the medium secure wards of Coleridge and Keats were reviewed by Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services, and scored 88% overall. At the same time the low secure ward, Byron, was also reviewed by the Quality Network for Forensic Mental Health Services. They scored 92% overall on a range of measures.
- A quality assurance team provider performance assessment report provided by NHS Wales dated 5 February 2015 stated that the hospital had met core service specifications in 69 of 78 areas assessed. The report praised areas of good practice including recent refurbishments and improvements of the environment. Where shortfalls had been identified, such as the continuing need for redecoration of the wards and poor evidence of evaluation of activities, the provider had put in place an assurance improvement plan that outlined how improvements would be achieved.

Forensic inpatient/secure wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The forensic inpatient/ secure wards at The North London Clinic are for male patients with a diagnosis of mental disorder and associated challenging behaviours. Some patients come direct from prison services for assessment and treatment of their mental health needs or have been in high secure environments. All the patients on the three wards were detained under the Mental Health Act 1983.

The forensic inpatient/ secure wards are Coleridge, Keats and Byron wards. Coleridge ward is a 17 bedded medium secure admission ward. Keats ward is a 15 bedded medium secure rehabilitation ward. Byron ward is a 10 bedded low secure ward.

Summary of findings

The forensic inpatient/secure wards were safe. Staff checked the emergency resuscitation equipment regularly to make sure it worked properly and was easily accessible. Staff knew how to recognise and report safeguarding concerns. Medicines were managed appropriately. The wards were clean and generally well-maintained. Staff completed risk assessments and developed risk management plans to minimise risks to patients and staff. Improvements were being made to ensure all areas of the wards could be observed at all times.

However, at night the hospital operated an on-call medical service and there was not always doctor available on site to respond to urgent needs. The allergies section on the medicine administration records on Coleridge ward were not always completed so as to ensure patients were not put at risk of receiving unsuitable medicines.

The forensic inpatient/secure wards were effective. Multi-disciplinary teams worked well together to care for and support patients. Comprehensive assessments of patients' needs were carried out on admission to the service. Care plans were in place to address patients' needs and these were reviewed regularly. There was good oversight of patients' physical health. Staff received appropriate induction, supervision and appraisal in their work. Staff used the Mental Health Act 1983 appropriately. Staff followed best practice guidance when providing care and treatment.

However, although staff had received some training in the Mental Capacity Act 2005 (MCA) most staff we spoke

Forensic inpatient/secure wards

with did not understand how the legislation affected their day to day practice. There was a risk that the needs of patients in relation to the MCA would not always be acknowledged and appropriate actions taken.

The forensic inpatient/secure wards were caring. Staff had a good understanding of individual needs. During the MDT meetings we observed patients were encouraged to express their views. Patients were involved in the running of the wards. They contributed to the development of hospital policies and decisions about improvements needed.

However, minutes of community meeting were not kept where they could be easily found by patients so that they knew what had been discussed and any actions being taken.

The forensic inpatient/secure wards were responsive. The wards were very aware of the diverse needs of patients and made positive attempts to promote cultural needs. There was good discharge planning. Patients were positive about the food and meals provided at the hospital. An individualised programme of activities was provided to patients on the wards.

However, it was difficult for patients on Keats ward to make telephone calls in private.

The forensic inpatient/secure wards were well-led. Staff were committed to the values of the organisation though did not always feel connected to senior managers. There were local governance processes that enabled managers and staff to identify where improvements were needed. Monitoring of incidents, complaints and safeguarding incidents were used to make improvements to the service. Some innovative practice took place to help improve the recovery of patients and prepared them for more independent living.

Are forensic inpatient/secure wards safe?

Safe and clean environment

- Most areas of the wards had good sightlines. However, on Keats ward the layout meant that some areas were not easily observed by staff. Risks were mitigated by staff walking around the areas several times an hour. Byron ward was 'T-shaped' which meant there were not clear lines of sight The wards were undergoing considerable refurbishment at the time of the inspection. Convex mirrors were awaiting installation. The mirrors would allow to staff to observe blind spots more easily. CCTV cameras were also being introduced.
- Detailed ligature risk assessments had been carried out on all the wards and were reviewed monthly. The ligature risk assessments identified high and medium risks on all wards. The provider had an action plan in place and was carrying out a programme of works that would address many of the existing risks. Ligature free rooms were due to be installed on all of the secure wards. The refurbishment of the secure wards was due to be completed by the end of September 2015.
- Emergency equipment, including defibrillators and oxygen were situated on the wards in the staff office. The equipment was checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Training records showed that staff had received training in life support techniques to enable them to respond effectively to emergencies.
- On Coleridge ward there were two seclusion rooms and one extra care area. The seclusion rooms had sight of a clock and most had intercoms to enable communication between the staff and patient being nursed in the area. However, there was no intercom for the ground floor seclusion area. Staff told us that patients had to gain the attention of staff observing them to enable communication. The door to the seclusion room on the first floor was situated in the middle of the bedroom corridor which meant that there was a degree of lack of privacy to the patients nursed in the area.

Forensic inpatient/secure wards

- The wards were clean and generally well-maintained. Where refurbishment was taking place, temporary 'airlocks' had been constructed to enable the safety of patients and workmen to be maintained, and tools kept safe.
- On Keats and Coleridge wards patients told us the toilets were often blocked and not always clean. The hospital refurbishment plan included improvements to all showers and toilets in the hospital. Cleaning audits showed that the cleanliness of the wards was monitored daily and areas needing attention were addressed promptly.

Safe staffing

- Both Byron and Coleridge wards had vacancies for four nurses. 'Bank' and agency staff covered these vacancies in most instances. The hospital was engaged in active recruitment and four new staff were waiting for checks to be completed before starting work.
- Additional staff were booked when patients needed one to one support or when more escorts were required to support patients to take agreed leave. However, on Byron ward there were occasions when patients were not able to take their leave due to staffing issues. Regular bank and agency staff were being used to provide some consistency to the service and to facilitate this. The hospital director was aware of the difficulty of making sure all patients could take agreed leave. Additional nursing and health care assistant shifts were being implemented to make sure that escorted leave could take place as planned.
- Staff told us that there were adequate numbers of medical staff available day and night to attend the ward quickly in an emergency. However, at night the hospital operated an on-call medical service. There was not always doctor available on site to respond to urgent needs.
- Staff had received and were up to date with appropriate mandatory training. The average mandatory training rate completion rate for staff was 97%. This included training in safeguarding adults, fire safety, life support techniques and infection control.

Assessing and managing risks to patients and staff

- We reviewed the risk assessments of 15 patients across all three wards. Staff completed risk assessments of patients when they were admitted to the wards. The assessment incorporated historical and known risk information. This information was used to develop risk management plans, which were reviewed regularly and updated after incidents. Measures were put in place to ensure that risks were managed. For example, the level and frequency of observations of patients by staff were increased if a risk had been identified.
- The hospital had a recovery approach to supporting patients. Byron ward had a positive risk-taking ethos, with less procedural and more relational security. There was a trial of patients having their mobile phone for set periods throughout the day. Patients used china plates and metal cutlery and had more access to their rooms than patients on the medium secure wards. Patients had been involved in devising the mobile phone policy.
- Coleridge ward was laid out over two floors, with sleeping accommodation on the first floor and communal areas on the ground floor. Staff needed to be present on both floors whilse some patients were still in their bedrooms. In order to manage the situation safely, the first floor was locked between the hours of 8:15am and 11:00am and again between the hours of 12.00pm and 3.00pm. Patients had no access to the ground floor between 8.30pm and 9.30pm. The floor was closed at 11.30pm. This was a blanket restriction which meant that patients could not access their bedrooms without a staff member until they were opened after the evening meal.
- On Keats and Byron wards there were areas where patients could make hot drinks. However, on Coleridge ward this facility was not available as the drinks machine had been broken. Patients were given hot drinks at set times, four times a day. Staff confirmed that patients were not able to have hot drinks outside of these times. We were concerned that this was a blanket restriction and was not based on patients' individual risk assessments. We raised this with the hospital director during the inspection. The restriction was reviewed and it was agreed that staff would provide hot drinks to patients whenever they made a request. A hot drinks machine was about to installed which would allow patients independent access to hot drinks.

Forensic inpatient/secure wards

- There had been 14 episodes of restraint in the previous six months. The highest number of restraints was on Coleridge ward. Three restraints were recorded as having been in the prone position or 'face down'. These were all on Coleridge ward. Department of Health 2014 guidance states that "there must be no planned or intentional restraint in the prone position." More recent guidance has clarified that there may be exceptional circumstances where the use of prone restraint will happen.
- Staff received training in breakaway techniques and restraint. Staff used de-escalation techniques to manage situations and minimise potential aggression. During the inspection there was an incident on Coleridge ward. Staff responded promptly and the patient was nursed on a one-to-one basis immediately to minimise risks to other patients and staff.
- We looked at the records of patients who had been given rapid tranquilisation to help manage violent behaviours. National Institute for Health and Care Excellence (NICE) guidance states that after the use of rapid tranquilisation the vital signs of patients should be monitored until they are alert. Patient records showed that this happened.
- There had been 16 episodes of seclusion and one incident of long term segregation in the previous six months. Most of these were on Coleridge ward.
- The records relating to the seclusion of patients were included within the daily progress notes and on a separate form entitled 'seclusion pack'. This did not enable a clear record of medical and nursing reviews, in accordance with the Code of Practice: Mental Health Act 1983 (CoP). There was no separate 'at a glance' record to ensure medical reviews took place at the correct times.
- We found that medical reviews of seclusion did not always take place regularly during the night. We reviewed records of three episodes of seclusion involving two different patients. The records showed that two hourly nursing checks had taken place as required throughout the seclusion period. The records for one episode showed that medical reviews of the seclusion had been carried out every four hours. For the other two episodes of seclusion there had been two occasions where medical reviews had not been carried out regularly at night. There was a gap of eight hours between medical reviews for one episode and a gap of nine hours and 15 minutes in the second episode.
- The provider was in the process of introducing a new seclusion policy which had been revised in line with the new MHA Code of Practice. This was implemented on 1 May 2015, the week after our inspection. The care of patients in seclusion and longer term segregation policy stated that patients in seclusion were to have face to face medical reviews every four hours, including during the night, until the first multi-disciplinary review took place and twice a day thereafter.
- Staff had received training in safeguarding vulnerable adults. Staff we spoke had a clear understanding of safeguarding and how to report it. Safeguarding alerts were made promptly in response to allegations or incidents that had occurred. There were flowcharts on display reminding staff of actions they needed to take.
- Appropriate arrangements were in place for the management of medicines. Medicines were stored securely. Records were kept of the temperature of the medicines fridge and clinical room in which medicines were stored. These showed that medicines were stored appropriately to ensure they remained fit for use. The records relating to the administration of medicines were accurate. There was on-going pharmacy review and management of the medicines on each ward through weekly medicine management audits. However, five of 12 medicine administration records on Coleridge ward did not contain information about whether the patient had any allergies. Without this information patients could be at risk of receiving inappropriate medicines.
- Where patients wanted to see their children, this was considered by the wider multi-disciplinary team to ensure it was in the child's best interests. A room away from the wards was available for patients to see their children.

Track record on safety

- There had been five serious incidents on the secure wards in the last 12 months.
- There had been a number of safeguarding incidents across the wards which related predominantly to patient on patient aggression. The wards took action in

response to these to ensure that management plans were updated to prevent recurrence. They provided additional support to patients to help them manage their anger and stay safe.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the provider's electronic incident recording system. All incidents were reviewed by the hospital director and other senior managers, who maintained oversight of the response to these. The system ensured that senior managers were alerted to incidents promptly and could monitor the investigation of these.
- In response to serious incidents that had occurred, the provider had taken action to prevent recurrence and ensure that all staff were aware of the incidents and trained in essential areas. For example, robust checks on equipment had been introduced to ensure that this was available and in fully working order in the event of an emergency.
- Staff were offered support after incidents had happened. Staff reported feeling supported by their team and ward managers. They were able to discuss incidents and any difficult feelings that arose as a result. Reflective practice sessions took place on each ward to enable staff to discuss incidents in a group setting.

Are forensic inpatient/secure wards effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- We looked at the care records of 15 patients. The care plans were up-to-date and personalised. In most cases the patient's view of the care plan was recorded.
- Each patient's physical health needs were assessed by medical and nursing staff within 24 hours of admission. Where a physical health need had been identified care plans had been implemented to ensure they were addressed, along with plans for routine monitoring. This included long term conditions such as diabetes. Care plans were developed to enable the patient to maintain as much independence as possible, whilst being monitored by staff.
- Physical health checks of all patients were carried out through a system of weekly weight, blood pressure, pulse and temperature monitoring. There was a dedicated physical health nurse who worked full-time. A GP held two sessions a week at the hospital. This meant there was good oversight of patients' physical health.
- Care plans were person-centred and recovery-orientated. They supported patients with their move through the hospital care pathway. Care plans were reviewed on a monthly basis and updated as appropriate.

Best practice in treatment and care

- We saw that staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions. Patient care plans were evidence based and referenced specific NICE guidelines, provider policies and best practice. The psychological therapies provided were in accordance with those recommended by NICE. They included mentalization based therapy and group work with patients with sexual offending behaviour.
- Each ward had an allocated psychologist. There was a programme of individual and group therapy that took place in the hospital, including psychology-based interventions. Some patients said they would like more access to individual psychological therapy. The psychologist said that all therapies were based on assessed need and best practice in relation to the patients' needs and behaviours.
- The hospital had a dedicated physical health nurse and medical staff who were available in an emergency during the day. There was an acute hospital in close proximity that could also be accessed in an emergency.
- Staff assessed outcomes for patients using the Health of the Nation Outcome Scales for Secure Services. These covered 12 health and social domains and enabled clinicians to build up a picture over time of patients' responses to interventions.
- The wards used a number of measures to monitor the effectiveness of the service provided. They conducted a range of audits on a weekly or monthly basis. We saw examples of audits of care plans, the systems for storing and administering medicines, explanation of patients' rights and physical health checks on all wards.

Forensic inpatient/secure wards

Skilled staff to deliver care

- Staff came from a range of professional backgrounds including nursing, medical, occupational therapy, social work and psychology. Each ward had an activity co-ordinator to support patients with activities and provide meaningful occupation.
- Staff received clinical supervision every four to six weeks. They used supervision to reflect on their practice and incidents that had occurred on the ward. Supervision records confirmed this took place regularly. Weekly reflective practice groups took place on all wards. Supervision arrangements supported staff to carry out their duties effectively.
- Staff received an annual appraisal of their work performance. The percentage of non-medical staff that had received an appraisal in the last 12 months was 88% for Keats ward, 91% for Coleridge ward and 100% for Byron ward.
- New staff, including bank and agency staff, completed a period of induction before working on the wards.

Multi-disciplinary and inter-agency team work

- All staff spoke positively about the multidisciplinary team (MDT) and how they worked well together to meet patients' needs. MDT working was evident in meeting records, care records and interviews with staff and patients. Each discipline respected the work of others and this supported their work with patients.
- We observed one MDT meeting and found this was an effective forum for sharing information about patients and the work of each discipline in respect of each patient. Different professionals worked together to assess and plan patient care and treatment.
- Teams had positive links with local authority staff and the care co-ordinators of patients. The MDT worked closely with external agencies such as drug and alcohol services and the local police. They worked with housing and volunteering organisations in arranging support for patients being discharged from hospital.

Adherence to the MHA and MHA Code of Practice

- Ninety seven per cent of staff had received training in the Mental Health Act 1983 (MHA). The staff we spoke with had a good understanding of the MHA. Detention paperwork was filled in correctly, was up to date and stored appropriately.
- We reviewed 12 medicine administration records on Coleridge ward and found that consent to treatment forms were attached to all the charts. However, in one case we found that a medicine had been prescribed, but was not recorded on the T3. This was rectified when brought to the attention of the consultant.
- The provider's systems supported the appropriate implementation of the Mental Health Act (MHA) and associated Code of Practice. Staff on each ward carried out regular audits to ensure the MHA was being implemented correctly.
- There was a good adherence to consent to treatment and capacity requirements overall and copies of consent to treatment forms were attached to medication charts where applicable. There was evidence that people had their rights explained to them on admission to hospital and throughout their stay.
- On all three wards patients had access to Independent Mental Health Advocacy (IMHA) services by referral. Information on IMHA services was provided to patients. Patients and staff knew how to access IMHA services.

Good practice in applying the MCA

- Staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards as part of their training on the Mental Health Act. However, most staff we spoke with did not understand how the legislation affected their day to day practice. There was a risk that the needs of patients in relation to the MCA would not always be acknowledged and appropriate actions taken.

Forensic inpatient/secure wards

Are forensic inpatient/secure wards caring?

Kindness, dignity, respect and support

- We observed positive and caring interactions between staff and the patients. Staff had good knowledge of patients and triggers to negative behaviours.
- Approximately 70% of patients we received feedback from were positive about the support they received from the staff. They said the staff listened to them and gave them encouragement to develop independence. However, a few patients said that staff were not always polite. They also said that some interactions, particularly in ward rounds, were focussed on incidents and what had gone wrong rather than giving feedback about positive areas where things had gone well.
- Information relating to patients was stored on the computers, which were only accessible to relevant staff. This ensured the information remained confidential. Discussions between patients and staff were held in private and away from other patients on the wards.

The involvement of people in the care they receive

- When patients arrived on the wards they were shown around and given a buddy who was another patient on the ward. The buddy helped orientate them to the ward and other staff and patients.
- During the MDT meeting we observed that patients were encouraged to express their views. Where they were not happy about the decisions made, these were discussed and the reasons for actions were explained.
- Care plans demonstrated that patients were involved in their care planning. These were sometimes limited to a direct quote from the patient, though others provided more detailed input from patients which demonstrated their involvement.
- Information about local advocacy services and independent mental health advocates was on display throughout the hospital. However, at the time of the inspection there were no advocates visiting the hospital. A new advocate was due to take over.
- Social workers took the lead for families and organised carers open days which consisted of a presentation on the work of different disciplines, such as psychology or social work. There were one-to-one sessions available for families, lunch and an opportunity for relatives to spend time with relatives. Information was given to families about the unit and families could attend their relatives' appointments with doctors if required.
- Each ward held community meetings with patients to gather their views about the ward and areas for improvement. The minutes of these were brief and held in the staff office areas, so were not readily accessible to patients to view what had been discussed.

Are forensic inpatient/secure wards responsive to people's needs? (for example, to feedback?)

Access and discharge

- The average bed occupancy for the wards over the last 6 months was 95%. All wards had a bed occupancy rate of more than 85%.
- Most patients had been in the hospital for less than two years.
- Planning for discharge was incorporated into the assessment of patients. Patients could move on to the rehabilitation service when they were ready, although this was dependent upon the agreement of commissioners.
- Discharges were planned with the involvement of community teams. Visits to new accommodation were arranged so that patients could have a say in where they lived after they were discharged.
- In the last six months there had been two delayed discharges from inpatient facilities. One of these was for a patient on Coleridge ward.

The facilities promote recovery, comfort and dignity and confidentiality

- The wards had a number of rooms for use, including lounges, dining rooms and clinic rooms. There was equipment available to support patients to occupy their time, such as games consoles, books and board games. Within the hospital patients could access the faith room, library, gym and games room by arrangement with their clinical team.

Forensic inpatient/secure wards

- Staff and patients on Coleridge ward told us that the temperature of the ward would become uncomfortably hot in the summer months, and there was limited access to fresh air. The hospital refurbishment plan showed that air conditioning work on Coleridge ward and the kitchens on Byron and Keats wards were due to be completed before the summer.
- Patients were able to make telephone calls in private on all wards apart from Keats ward, where the telephone was situated in the corridor with no hood to enable privacy when making calls. The hospital refurbishment plan included the installation of telephone doors on Byron and Coleridge wards but made no specific mention of Keats ward.
- Patients had access to outside space, though this was timed so patients could be supervised by staff when using these areas to minimise risks. Most patients were not able to access outside areas when they wished.
- Patients were positive about the food and meals provided at the hospital. Snacks were available outside of mealtimes, such as fruit and biscuits. Toast could be prepared on request.
- Patients were able to securely store their possessions in their bedrooms.
- There was a full time occupational therapist (OT) and a full time activities coordinator for each ward. English and maths tutors provided individual tuition for patients on referral. A full individualised programme of activities was devised with patients.
- There were different levels of activity provision across the wards. Feedback from patients and staff was that therapeutic activities took place and were rarely cancelled. However, some ward-based activities did not always take place due to a lack of permanent staff to ensure these took place.

Meeting the needs of all people who use the service

- The hospital wards were not easily accessible to patients with mobility needs due to the nature of the building.
- Staff received training in equality and diversity as part of their mandatory training. Patients and staff had access to interpreters to support patients at meetings about their care and treatment. Patients' cultural and religious needs were assessed and any particular dietary needs were accommodated.
- Some local faith representatives visited patients on the wards, whilst others could be contacted to request a visit. Patients, who wished, were escorted to local places of worship, dependent upon their leave entitlement.

Listening to and learning from concerns and complaints

- Patients knew how to raise a complaint, or would discuss any concerns with the ward manager. Information on how to make a complaint was displayed in the wards.
- Where complaints had been received by the ward, these were recorded in the ward complaints book. This recorded the complaint and actions taken to resolve it. The records showed that complaints were dealt with promptly and patients were satisfied with the response. Where complaints could not be resolved at a local level, they were escalated to the patient safety and engagement lead within the hospital. The patient safety lead visited each ward to speak to patients. She monitored the complaints record book and the actions taken, to ensure that concerns were investigated and responded to appropriately by staff.
- Ward managers showed us where learning from complaints was used to make changes to the ward, such as in relation to the new meal menu, and games consoles being provided for use.

Are forensic inpatient/secure wards well-led?

Vision and values

- Staff were aware of the provider's values. They spoke of being committed to these and using them in their day-to-day work.
- Staff said they were well supported by their peers and the ward managers. However, many staff on the wards spoke of not feeling connected with senior managers

and felt they did not have an understanding of the pressures of their work. This reflected the findings from the 2014 Partnerships in Care staff survey, which found that some staff did not feel valued by senior managers.

Good governance

- Effective local governance processes were in place. Performance information was provided to ward managers. This included information about safeguarding figures, medicine incidents such as training and supervision that staff had completed, and staff sickness and absences. Information about the staffing of wards was collated and monitored, along with physical health checks.
- The wards carried out weekly audits, such as audits of physical health checks, patient monies, care planning and risk management planning. This ensured that care plans were up-to-date and individual areas of risk were monitored and addressed.
- Monitoring of incidents and complaints took place. Action plans were developed to address any learning from these.
- Staff checked that the requirements of the Mental Health Act were being followed on each ward. Details on the office whiteboards reminded staff to speak with patients about their rights on a regular basis.
- Staff monitored infection control and hygiene of the wards on a monthly basis through cleanliness audits to ensure that all areas were hygienic for the patients.

Leadership, morale and staff engagement

- The wards were well-led by their managers. Ward managers were visible on the wards during the day, were accessible to patients and provided support and guidance to staff. The culture on the wards was open and staff felt encouraged to bring forward ideas for improving the service patients received.
- Staff were committed to their work and to providing a good service to patients.
- Staff were aware of whistle-blowing processes and felt able to report concerns and improvements needed within the hospital. They were confident they would be listened to by the ward manager.
- Ward managers received leadership training, which they found enhanced their work and skills as a manager.

Commitment to quality improvement and innovation

- The hospital had implemented a 'real work programme' which gave patients the experience of working in the hospital. The programme reflected the actual process of applying for a job, developing a CV, being shortlisted, having an interview and being paid a therapeutic wage for working in the particular role. This enabled patients to develop essential skills to support them in their recovery and prepare them for work when they were discharged from hospital.
- The hospital ran 'living together' groups on the wards. These brought together groups of patients to talk about how to improve their environment and experience in the hospital. Several improvements had resulted from the work of these groups. For example, blanket restrictions on Byron ward had been changed. Mobile phones, metal cutlery and new crockery had been introduced. Staff and patients worked together in the groups to produce policies and ways of doing this safely.
- In September 2014 the medium secure wards of Coleridge and Keats were reviewed by Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services, and scored 88% overall. At the same time the low secure ward, Byron, was also reviewed by the Quality Network for Forensic Mental Health Services. They scored 92% overall on a range of measures.

Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Tennyson House is a rehabilitation and recovery ward. The ward has 19 beds. The patients are all male. All patients on the ward, except one, were detained under the Mental Health Act 1983 at the time of the inspection.

Summary of findings

The long stay/rehabilitation mental health wards for working-age adults were safe, effective, caring, responsive and well-led. A ligature risk assessment had been completed on the ward and improvement work was scheduled to take place. Risks were being mitigated with individual risk assessments and observations as required. Patients had up to date risk assessments and were involved in writing these. Emergency equipment was accessible and being checked regularly by staff. The number of staff on shift was sufficient to meet the needs of patients. Activities and escorted leave were rarely cancelled because of a shortage of staff. Staff knew how to recognise different forms of abuse and how to report it.

There were detailed assessments of both mental and physical health for all patients and care plans reflected the information in the assessments. Care plans were up to date, holistic and recovery orientated. Patients received physical health checks and could access a GP as required. Most staff had completed mandatory training and some had attended additional training to develop their skills. Patients had access to psychological therapies. There was a strong multi-disciplinary team who worked well together. Staff showed a good understanding of the Mental Health Act, Code of Practice and guiding principles as well as the Mental Capacity Act. Patients had their rights explained to them on a regular basis. There was a good range of group and individual activities on the ward both therapeutic and social activities and active community integration work took place.

We observed positive, kind and caring interactions between staff and the patients. Staff knew patients and

Long stay/rehabilitation mental health wards for working age adults

understood their individual needs. Patients were routinely involved in their care planning, ward rounds and CPA reviews. Families and carers were welcome on the ward and involved in care planning and decision making. Patients were treated respectfully by staff.

Ward facilities were good and were used well to meet the individual needs of patients. The food was of good quality. Patients' personal preferences were taken into account when meals were prepared. Staff recorded complaints and these were responded to appropriately. The reporting of complaints was encouraged.

Staff understood and shared the values of the organisation and were committed and passionate about the work they did. We saw examples of innovative practice. The culture of the ward was open and staff members were encouraged to be transparent and share learning. There was good leadership at a local level and a culture of and commitment to continual improvement.

Are long stay/rehabilitation mental health wards for working-age adults safe?

Safe and clean ward environment

- A detailed ligature risk assessment had been completed for the unit. This identified and categorised the ligature risks throughout the building. There was an identified time frame for remedial work to be completed. There were plans in place to manage or mitigate the risks to patients from ligature points. Mitigating actions included daily environmental checks, individual risk assessments and increasing levels of observation when required. The patients admitted to Tennyson House were generally low risk for self-harm and suicide. The primary focus of the ward was rehabilitation and recovery.
- Emergency equipment was accessible and checked daily to ensure it was fit for purpose. The emergency medication was in place and within the expiry date.
- The ward and bedrooms were clean, had reasonable furnishings and were well maintained. Patients had been involved in choosing new furniture for the communal areas. The kitchen areas in some of the flats were not very clean. Patients were encouraged to clean their own living areas and had access to cleaning materials. General housekeeping was provided daily and the nursing staff completed cleaning as required.
- The ward was over three floors with bedrooms on the ground floor and upper levels. There were four bedroom areas known as flats and a three bedroom area on the ground floor. This was used for those patients with higher support needs or who needed to be observed more closely.
- A detailed environmental audit of Tennyson House had been carried out at the end of March 2015. This identified, for example, where furniture was missing or in need of repair, where rooms or fittings were in need of deep cleaning, and where flooring needed to be replaced. A plan was in place to track the progress of the actions that were needed. We saw that most of the actions were completed or furniture items were on order. The flooring had been replaced in some areas of the unit and the work was continuing during the inspection.

Long stay/rehabilitation mental health wards for working age adults

Safe staffing

- During the day there was a minimum of two qualified nurses and three healthcare support workers on duty. A healthcare support worker worked from 9.00am to 5.00pm to provide additional support. At night there were two qualified staff and two healthcare support workers. These staffing levels had been estimated using a recognised tool and were sufficient to meet the needs of patients. Patients were able to take agreed escorted leave and had access to staff when they needed to speak to someone.
- Copies of the staff rota showed the number of staff on duty normally reflected safe staffing levels. However, the rota for the week prior to the inspection showed three days when there was not the required number of nurses or health care support workers on duty. The ward manager explained there had been a staff shortage due to staff sickness and annual leave. Cover had been arranged from an agency and planned training was cancelled for a regular staff member to bring them back to the ward. These measures ensured patients were not put at risk, but the rota had not been updated to show the actual number of staff on duty.
- Safe staffing levels were sometimes maintained using bank and agency staff. Two agency staff had been given short term contracts to provide cover while new staff were recruited. This helped provide continuity of care to patients. Regular bank staff were also used to maintain consistency. The ward manager was able to bring in additional staff when needed.
- Patients were able to take up leave as agreed. Staff negotiated times for escorted leave with patients so that all patients could take their leave. Activities and agreed escorted leave were rarely cancelled due to staff shortage.
- During the day there was a consultant psychiatrist available to provide medical cover. At night there was no on site doctor. There was an on-call doctor available out of hours. Staff told us they rarely needed to consult the out of hours doctor.

Assessing and managing risk to patients and staff

- We reviewed the care records of three patients in depth. Patients had up to date risk assessments in place. These were reviewed regularly and after incidents. Patients reported they were involved in their own risk assessment.
- Individual assessments regarding restrictions on patients formed part of care plans. For example, one patient had restrictions on the amount of clothing he was able to have at any one time in order to maintain his safety.
- There was a blanket policy of searching patients when they returned from unescorted leave in order to maintain the safety of all patients. There was a policy and procedure in place to support staff to do this safely and with the patient's consent.
- The use of restraint was rare. There had been one incident of restraint in the last six months. This had not been face down restraint and rapid tranquilisation had not been used. Staff were trained in the safe management of violence and aggression and de-escalation techniques. This was updated every year. Staff were clear face down restraint should not be used. Staff knew patients well and understood individual triggers that could lead to an incident.
- Staff had completed mandatory training in safeguarding adults. Staff knew how to recognise abuse and how to report it. The majority knew the lead social worker was the safeguarding lead for the hospital.
- Medicines were managed safely. There were regular audits of the medication administration records to ensure they had been completed appropriately. The majority of patients reported they received their medication at a regular time each day. There were daily checks on fridge temperatures to ensure medicines requiring cold storage were kept at the right temperature. Medicines were stored securely in locked cabinets. There was a locked container in place for a patient who was self-medicating on the ward. All medicines were signed for when given. If medicines were not given, a code was recorded on the medicine chart explaining the reason for this.

Long stay/rehabilitation mental health wards for working age adults

Track record on safety

- There had been one serious incident on the ward between May 2014 and February 2015.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and were encouraged to do so by the ward manager.
- The service had a process for investigating incidents and cascading learning from incidents to managers and staff.
- Staff members received full support after a serious incident including a debrief and opportunities for reflective practice in team meetings.

Are long stay/rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- We reviewed the care records of three patients. There were detailed assessments in place for patients. These covered both mental and physical health needs. Where needs were identified care plans had been put in place to address these and ensure staff knew how to meet patients' needs. At the multi-disciplinary meeting we observed it was clear the staff team knew the patients well and considered all their needs, including social care needs post discharge.
- Patients had all received a physical health assessment including a full physical examination on admission. Each patient had an annual physical health check.
- Care plans were up to date, holistic and recovery orientated. In two care plans there was good recording of patient involvement in the care planning process and their comments on the plans were included. On the third care plan it was recorded that the patient had declined to comment. Care plans included patients' goals and future plans. These matched what patients told us.

Best practice in treatment and care

- We saw that staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions. Patient care plans were evidence based and referenced specific NICE guidelines, provider policies and best practice.
- Patients in the service had access to psychological therapies and were offered support on an individual basis. Psychology staff ran core sessions across the service which included a 'hearing voices' group. There was a 'mindfulness' group for patients on Tennyson ward.
- Patients were registered with a GP off site. A GP visited the service regularly and treated minor illnesses. The majority of patients stated they had regular health checks and if they felt unwell the staff listened to them and responded appropriately. Individual health conditions were being managed appropriately.
- Staff used Health of the Nation Outcome Scales to measures outcomes for patients. The occupational therapist assessed patients using the model of human occupation screening tool (MoHOST). They provided group and individual sessions to patients based upon their assessed needs. MoHOST was used to evaluate the progress of patients. This was redone every six months.
- Staff carried out a range of audits on the ward. These included audits of medicines management and clinical records. Where improvements were needed action plans were put in place to track progress with these.
- From Monday to Friday there was a wide range of therapeutic activities available on an individual and group basis on the ward and in the recovery centre in the main hospital. At the weekend there were less structured activities and these were provided mainly by the nursing staff. The therapeutic programme was reviewed every 12 weeks. Patients were consulted on the content of the programme. However, if an activity was clearly unpopular this could be changed or modified before the 12 weeks review.
- Patients were generally satisfied with the range of activities available and were involved in planning activities at the weekly community meeting. Efforts were made to involve patients in groups or provide individual activities when this was preferred. Patients completed an interests checklist on admission and had an individual activity timetable based on this.

- Patients were able to apply for a paid job in the service through the real work programme. An employment skills group helped patients develop a CV, practice interview skills, and take part in a mock interview. This helped patients secure a position in the real work programme. The occupational therapist led community integration groups for patients and encouraged them to use local facilities such as the leisure centre. A recovery and outcomes group focussed on individual patient goals and feasible plans.
- Maths and English tutors came into the service and provided individual tutorials to improve patients' literacy and numeracy skills. A maths tutor was present during our visit to the ward.

Skilled staff to deliver care

- There was a strong multi-disciplinary team, led by an experienced ward manager and consultant psychiatrist. In addition to medical and nursing staff there were psychologists, an occupational therapist, healthcare support workers and a social worker.
- All new staff completed an induction before taking up their full responsibilities on the ward.
- Staff received supervision monthly and this mostly took place as planned
- Seventy six per cent of non-medical staff on Tennyson House had received an annual appraisal. Three of the four staff who had not had an appraisal were in their probationary period.
- Staff were positive about the mandatory training they could access to support them to perform their role. Some staff had undertaken additional training such as motivational interviewing and behavioural activation which they had been able to use in their day to day work. A healthcare support worker told us they had been supported to pursue an access to nursing course by the hospital and he was now applying to do his nurse training.
- Staff performance issues were addressed through on-going supervision.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary team (MDT) meetings were held weekly and led by a senior member of the team. The MDT meetings and ward rounds were well attended and the holistic needs of patients were discussed. Patients attended the meetings and were able to discuss and ask questions about their care and treatment.
- Regular handovers took place between shifts enabling effective sharing of essential information. We observed staff handing over important information about patients including changes to medication and risks.

Adherence to the MHA and the MHA Code of Practice

- Staff showed a good understanding of the Mental Health Act and associated Code of Practice.
- Consent to treatment and capacity requirements were met and treatment forms were attached to medication charts where applicable.
- Staff explained patients' rights to them on admission and at regular intervals after that. Records indicated this was taking place and appropriately recorded. The majority of patients we spoke with stated they remembered being told about their rights.
- There were notices about the availability of independent mental health advocacy on the ward. The service could be contacted by staff and patients directly during visits by the advocate or by telephone on the publicised number.

Good practice in applying the MCA

- Staff training records and deprivation of liberty safeguards or were booked to attend the training. The majority of staff members demonstrated good understanding of mental capacity and the five statutory principles.
- There was good recording of discussions regarding capacity and assessments had been carried out when required. We saw records of a current example where staff had concerns about the patient's behaviour and decision making. The patient's capacity was properly assessed and recorded. The patient was involved in the process, decision making and agreed actions.

Long stay/rehabilitation mental health wards for working age adults

Are long stay/rehabilitation mental health wards for working-age adults caring?

Kindness, dignity, respect and support

- We observed positive, kind and caring interactions between staff and patients.
- Some patients told us that some staff listened to them while others appeared to lack interest. Two patients spoke about staff using keys to enter bedrooms unannounced and feeling they were not always treated with respect. However, the majority of patients were positive about staff and said there was always someone they could talk to.
- Staff knew their patients and their holistic needs very well. This was demonstrated in the MDT meeting we observed and in individual discussions with staff.
- Care was person centred and recovery orientated.

The involvement of people in the care they receive

- Staff described how new patients were introduced to the ward. This included showing patients around and introducing them to staff and other patients. The occupational therapist provided patients with a leaflet explaining the role of occupational therapy.
- Patients were routinely involved in care planning, ward rounds and care programme approach reviews. The majority of patients said staff involved them in their care, although one person told us he thought decisions were made for him without listening to what he wanted. Some patients told us they did not have a copy of their care plan, but stated they had been involved in writing the plan. Care plans were written in clear and accessible language.
- There was strong evidence of family involvement in care. Rooms were available for patients to see friends and relatives in private and they were welcome on the ward. The safety of visitors was monitored while they were in the unit.
- The ward had a weekly community meeting which was usually led by the occupational therapist. These were well attended by staff and patients and decisions were made about the arrangements for the week ahead. Minutes were kept of the meetings. However, they did not contain detailed information and were not displayed in a communal area in the ward where patients could see them.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Access, discharge and bed management

- Patients came from different parts of the country. Many moved through the care pathway from the secure wards in the hospital to the rehabilitation unit. Staff supported patients to keep in touch with relatives. Relatives could visit the hospital. Some patients used information technology to keep in touch with their families.
- Discharges were rarely delayed. There had been one delayed discharge in the last six months. Staff told us of a patient who was waiting for an appropriate placement in the London area. Sometimes patients did not want to return to their local area and it could take some time to find a local mental health team willing to take responsibility for their care. This could lead to a delay in their discharge.
- The service had a good relationship with care-coordinators. Twelve commissioners of the service and care coordinators provided feedback about the service prior to the inspection. Most were very positive about the service and said staff communicated well.

The ward optimises recovery, comfort and dignity

- The ward had good facilities, including areas for activities and therapies. There were meeting rooms where families could meet.
- There was a dedicated patient phone on the ground floor. Patients reported there were problems with the phone at night as they were in their flats and could not hear and therefore answer the phone. Some patients had their own mobile phones and could make calls from their own bedrooms. Patients were risk assessed before being allowed a phone

Long stay/rehabilitation mental health wards for working age adults

- The ward had a secure garden. For patients who were interested in gardening there was a project to try and improve the facilities in the garden in order to grow vegetables.
- Patients were complimentary about the meals which offered a good choice. The occupational therapist supported patients to develop their cooking skills. Several patients who lived in communal flats in the unit shopped for and prepared their own meals. We spoke with one patient as he prepared a cooked breakfast in his flat kitchen.
- Snacks such as toast and sandwiches were available to patients in their own flat kitchens. Bowls of fruit were available in the dining room. There was a hot drinks machine and water cooler which was available to patients when they wished. Patients could buy their own snacks or drinks when they had leave and they stored these in their rooms or kitchens. The hospital had a 'collapsible' shop which sold a small range of items and was open at set times.
- Patients were able to personalise their bedrooms with their own belongings, such as posters, wall coverings and a television. Patients all had keys to their rooms and were able to keep their possessions safe.

Meeting the needs of all people who use the service

- The ward had rooms on the ground floor that enabled access for those with a physical disability, but the hallway was narrow and might not have been suitable for all wheelchair users.
- There were information leaflets for patients which were available in different languages if required. Interpreters could be obtained for patients who did not speak English well. Staff provided examples of when an interpreter had attended ward rounds and key meetings with a non-English speaking patient.
- Staff were aware of patients' cultural needs, backgrounds and preferences. An African patient was supported to have food that he was used to and liked. Patients were supported to have meals appropriate to their religious needs.

Listening to and learning from concerns and complaints

- There had been 13 complaints on Tennyson House in the previous 12 months. These included complaints about staff attitude, patient leave and access to care records. Two complaints had been upheld and two complaints had been partially upheld.
- Most patients we spoke with said they knew how to complain. We saw posters and leaflets displayed on the ward which explained the complaints procedure. A patient who had made a complaint told us it had been managed professionally by staff.
- Staff said they generally tried to respond to verbal complaints immediately. Complaints were recorded in the complaints book. The patient safety and engagement lead visited the ward regularly. There was a system for recording informal complaints and responding to patients which the patient safety lead encouraged staff to do.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Vision and values

- Staff knew the names of senior staff in the organisation and said they had visited the ward. They felt they had opportunities to raise issues with senior managers. Senior managers had recently held a drop in where staff could go to ask questions or raise any issues. Some staff told us they had attended and found this useful.

Good governance

- The ward was well managed and led by the ward manager and consultant psychiatrist. Staff and patients were positive about the management team.
- Governance systems enabled the ward manager to run the ward effectively and maintain fundamental standards of care and treatment.
- Staff had completed mandatory training and were able to access additional training courses. All staff had received an annual performance appraisal and supervision normally took place as planned.

Long stay/rehabilitation mental health wards for working age adults

- Staff participated actively in clinical audits on the ward in order to monitor standards of care and check that hospital policies and procedures were being followed.
- There were clear channels for reporting incidents and escalating risk information. Learning from incidents and complaints was disseminated to staff and led to improvements in care.

Leadership, morale and staff engagement

- Staff knew there was a whistle-blowing process and knew how they could raise concerns senior managers. Staff felt comfortable raising any concerns they had about safety and the quality of care and treatment provided. They felt they would be listened to and action taken where required.
- Morale was good amongst staff on the ward.

Commitment to quality improvement and innovation

- Staff looked at ways to work innovatively with patients. This included a multi-disciplinary programme designed to work with those patients who did not engage with group sessions and who reported they felt demotivated. The staff involved in designing the programme were passionate and positive about having an opportunity to lead on a new way of working and trying to ensure better outcomes for a specific group of nine identified patients.
- The real work programme was a hospital wide initiative. Some Tennyson patients had applied for roles and been successful. They said they had enjoyed it and found it assisted their recovery