

Requires improvement 

# Derbyshire Healthcare NHS Foundation Trust

## Forensic inpatient/secure wards

### Quality Report

Derbyshire Healthcare NHS Foundation Trust  
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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXM14	Kingsway site	Kedleston Unit	DE22 3LZ

This report describes our judgement of the quality of care provided within this core service by Derbyshire Healthcare Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Derbyshire Healthcare Foundation Trust and these are brought together to inform our overall judgement of Derbyshire Healthcare Foundation Trust.

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

### Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



### **Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**

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

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

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

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	5
Information about the service	9
Our inspection team	9
Why we carried out this inspection	9
How we carried out this inspection	10
What people who use the provider's services say	11
Areas for improvement	11

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### Detailed findings from this inspection

Locations inspected	12
Mental Health Act responsibilities	12
Mental Capacity Act and Deprivation of Liberty Safeguards	12
Findings by our five questions	14
Action we have told the provider to take	28

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# Summary of findings

## Overall summary

We re-rated forensic inpatient/secure services as **requires improvement** overall:

- Staff did not consistently assess patients for their risk of violence through completion of risk assessments for two patients.
- Staff had not received the training needed to ensure patients' safety and wellbeing.
- Building work on the seclusion suite was in progress but not yet completed.
- The work that the trust had identified was needed to reduce environmental and ligature risks had not been completed at the time of the inspection. However, building plans and a schedule of works was available.
- Staff had not removed all unsafe items from the garden so that patients were at risk of harm.
- Some furnishings for use by patients were not clean and not in good condition.
- Patients' capacity to consent to care and treatment had not always been formally assessed and recorded.
- Staff did not offer patients the opportunity to record their preferences in an advance directive (a statement written by the patient of their decision to refuse treatment at a time they do not have the mental capacity to make this decision).
- Scheduled activities in the evenings and at weekends were not always available for patients.

However, at this inspection we also found the following improvements had been made:

- Patients were involved in care planning.
- Doctors requested second opinion appointed doctors (doctors employed by the care quality commission to give a second opinion where patients are detained under the Mental Health Act) in a timely manner.
- Medicines were stored at the correct, safe temperature.

- Robust systems and processes were in place to support safeguarding patients. Safeguarding referrals were made when appropriate.
- Staff cleaned seclusion rooms and changed bedding between uses.
- A clock was visible from the seclusion room to allow patients to know the time.
- Staff completed patients' detention papers and filed them appropriately.
- There was a way of informing ward staff whether temporary staff booked to work were competent and up-to-date with 'control and restraint' (physical intervention that staff may use to help patients calm down) training.
- Gender ratios of staff were appropriate to meet the needs of patients in a timely manner.
- Training provided to staff was factually accurate.
- Audit processes identified missing parts in patients' care records.
- Patients had their medicines dispensed in a location which upheld their privacy, dignity and confidentiality.
- Staff displayed information relating to the complaints procedure, patient advice and liaison service and the care quality commission on the wards.
- Staff completed a physical health assessment of each patient on their admission to the service.
- The seclusion and long-term segregation policy was accurate.
- Following our inspection in June 2016, we rated the service as **good** for responsive.
- The forensic inpatient/secure service were now meeting Regulations 13, 15 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

# Summary of findings

## The five questions we ask about the service and what we found

### Are services safe?

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

- At our previous inspection, seclusion facilities did not comply with standards set out in the Mental Health Act (1983) or the Code of Practice (2015). For example, there was no two-way communication and patients did not have access to toilet and bathroom facilities without going out of the seclusion room. In December 2016 work had begun on building a new seclusion unit, however, the one in use at the time of the inspection did not comply with standards set out in the Mental Health Act (1983) or the Code of Practice (2015).
- In June 2016, managers had not addressed all environmental risks, including ligature risks, identified through annual audit. In December 2016, some ligature risks had been removed and action had been taken to create a safer environment for patients. Further work was needed to ensure all environmental risks were reduced. The secure garden still included some items that could put patients at risk of harm, such as vermin bait boxes and smoking shelters, which posed a ligature risk.
- At our previous inspection, soft furnishings on Curzon ward were dirty, worn and threadbare on the arms of chairs. Fabric was torn in some places. In December 2016, new furniture had been ordered.
- In June 2016, low numbers of staff were up-to-date with basic life support and intermediate life support training. At this inspection only 74% of staff had received training in basic life support and 58% in intermediate life support. This meant there were not enough staff trained to ensure there was always a first aider on every shift.
- In June 2016, we found that completion of the historical clinical risk version 3 (HCR20v3) risk assessments was inconsistent; some patients had not been screened at all. This is a comprehensive set of professional guidelines for the assessment and management of violence risk. In December 2016 we found that two of the 13 risk assessments had not been completed.
- However, we also found at our inspection in December 2016 that managers had not audited staffing levels to ensure they knew when escorted leave or ward activities are cancelled due to too few staff. This could mean that managers might not take action to action this.
- We also found that doctors experienced in forensic psychiatry were not available at all times.

Requires improvement



# Summary of findings

However:

- The service had partly addressed the issues that had caused us to rate safe as inadequate following the June 2016 inspection.
- In June 2016, managers had not addressed all environmental risks, including ligature risks, identified through annual audit. In December 2016, ligature risks had been removed or action had been taken to reduce these risks. The secure garden still included some items that could put patients at risk of harm, such as vermin bait boxes. However, staff supervised patients when using the garden which reduces risks.
- At our inspection in June 2016, records did not show that patients subject to restraint, seclusion or rapid tranquillisation medicine had been physically monitored by staff following any of these interventions. In December 2016, staff had recorded this.
- At our previous inspection, bank nursing staff were not always competent and up-to-date with 'control and restraint' training for managing violence and aggression. At this inspection we found that staffing levels were safe and most staff had received training in control and restraint.
- At our inspection in June 2016, the clinic room was cramped and cluttered and emergency equipment was not easily accessible. In December 2016, the clinic room was clean and organised.
- At our previous inspection there was not a clock visible from the seclusion room so that patients would be able to see the time. At this inspection, clocks were visible.

## Are services effective?

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

- At our inspection in June 2016, we found that staff understanding of mental capacity was poor. We found in December 2016 that staff had not received training in and some staff lacked understanding in the Mental Capacity Act.
- In June 2016 staff had not undertaken any formal assessments of mental capacity for any patients. At this inspection, staff had not appropriately completed assessments of patients' capacity to consent to decisions about their care and treatment.
- At our inspection in December 2016 we also found that non-medical staff had not received regular management or clinical supervision.

However:

**Requires improvement**



# Summary of findings

- The service had partly addressed the issues that had caused us to rate effective as inadequate following the June 2016 inspection.
- At our inspection in June 2016, doctors had not consistently provided all patients with physical health assessments on admission. At this inspection, all patients had an assessment of their physical health completed on admission. Patients' physical health was monitored during their stay on the unit.
- At our previous inspection, patients' care plans were not personalised, holistic or recovery oriented. In December 2016, all patients' care plans we looked at were personalised, holistic and recovery oriented.
- In June 2016 doctors had not requested second opinion appointed doctors in a timely manner. This had improved at this inspection.
- At our previous inspection we found that Mental Health Act documentation was chaotically filed on the ward. This had improved at this inspection so that staff knew under which legal authority they were providing care and treatment.

## Are services caring?

We re-rated caring as **good** because:

- The service had addressed the issues that had caused us to rate caring as requires improvement following the June 2016 inspection.
- At our inspection in June 2016, patients' care records did not demonstrate that patients were actively involved in care planning and were not offered a copy. In December 2016, patients were involved in their care plan and staff offered them a copy of this.
- At our previous inspection, patients were not involved in service development. At this inspection, patients met fortnightly on the ward to discuss the running of the ward and service and what affected them.

However:

- In June 2016, we found that patients did not have advance directives in place. This remained outstanding at this inspection.

Good



## Are services responsive to people's needs?

- At the last inspection in June 2016 we rated responsive as **good**.

Good



# Summary of findings

- **Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.**

## Are services well-led?

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

- We found during our inspection in June 2016, governance process had failed to identify or protect people from unsafe care. Ward systems were not effective in ensuring that staff received mandatory training. Staff compliance with key training such as basic life support, intermediate life support and medicines management was low and did not meet trust expected targets. At this inspection we found governance systems had improved but had still not identified all the risks to the safety and welfare of patients. For example, staff had not received sufficient training in life support and the service had not reduced some of the environmental risks.

At our inspection in December 2016, we also found:

- Staff had not received regular supervision.
- The interim manager was due to return to their previous post and a new manager had started working at the service the week before our visit. Staff told us that management changes had affected their morale and they were unsure of the expectations of their role.

However:

- The service had partly addressed the issues that had caused us to rate well led as inadequate following the June 2016 inspection.
- At our previous inspection, staff did not know the trust's vision or values. Staff spoken with at this inspection were aware of these.
- At our inspection in June 2016, staff did not routinely monitor patients' physical health following the use of restrictive interventions and/or rapid tranquillisation. At this inspection staff monitored all patients' physical health needs.
- In June 2016, the trust policy governing the use of seclusion was inaccurate. There was under-reporting of the use of seclusion so it would not be possible for the trust to be working on accurate data towards achieving their aspiration. The policy had been updated and reporting had improved at this inspection.

Requires improvement



# Summary of findings

## Information about the service

The Kedleston Low Secure Unit provides a low secure service for male patients. Its purpose is to deliver intensive, comprehensive, multidisciplinary treatments and care by qualified staff and healthcare assistants.

The service provides care for men aged 18 years and above who suffer from a mental disorder, and are detained under the Mental Health Act 1983. They require treatment in a specialist low secure service, and usually have complex and challenging forensic and mental health needs.

There are two wards at the Kedleston Unit: Curzon is the admission and assessment ward, and Scarsdale is the rehabilitation ward. Curzon Ward has eight beds and Scarsdale Ward has 12 beds; bedrooms are not en suite on either ward and patients have access to shared bathroom facilities.

When the CQC inspected the trust in June 2016, we found that the trust had breached regulations. We issued the

trust with seven requirement notices for forensic inpatient /secure services. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 HSCA (RA) Regulations 2014 Person centred care
- Regulation 11 HSCA (RA) Regulations 2014 Need for consent
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

## Our inspection team

Our inspection team was led by:

Sarah Bennett inspector.

The team that inspected the Kedleston Unit consisted of one CQC mental health hospital inspection manager,

three CQC mental health hospital inspectors, one specialist adviser who had experience as a senior mental health nurse and one expert by experience (a person who has used mental health services).

## Why we carried out this inspection

We undertook this inspection to find out whether Derbyshire Healthcare NHS Foundation Trust had made improvements to its forensic inpatient/secure wards since our previous comprehensive inspection of the trust on 6-10 June 2016. We issued the trust with a warning notice that required improvements to be made.

When we inspected the trust in June 2016, we rated forensic inpatient/secure wards as **inadequate** overall.

We rated the core service as inadequate for safe, effective and well-led; as requires improvement for caring; and as good for responsive.

Following the June 2016 inspection, we told the trust that it must take the following actions to improve forensic inpatient/secure wards:

- The trust must ensure that patients are fully involved in care planning.

# Summary of findings

- The trust must ensure that patients are offered the opportunity to record their preferences in an advance directive.
- The trust must ensure that patients' capacity to consent to care and treatment is formally assessed and recorded.
- The trust must ensure that second opinion approved doctors are requested in a timely manner.
- The trust must ensure that patients are consistently provided with historical clinical risk management, version 3 risk assessments and that these are reviewed and updated to reflect changes in risks.
- The trust must ensure that staff compliance with mandatory training is significantly improved.
- The trust must ensure that facilities used for the purpose of seclusion are of sufficient size to safely accommodate a resistive patient and a minimum of three staff when implementing seclusion.
- The trust must ensure that mitigating actions identified in relation to environmental and ligature risks are undertaken.
- The trust must ensure that medicines are stored at the correct, safe temperature.
- The trust must ensure that robust systems and processes are in place to support safeguarding patients. Safeguarding referrals must be made when appropriate.
- The trust must ensure that seclusion facilities are cleaned and bedding changed between uses.
- The trust must ensure that a clock is visible from the seclusion room to allow patients to independently orient themselves to time.
- The trust must ensure that patients' detention papers are appropriately filed and complete.
- The trust must ensure that there is a way of informing ward staff if temporary staff booked to work are not competent and up-to-date with 'control and restraint' training.
- The trust must ensure that gender ratios of staff are appropriate to meet the needs of patients in a timely manner.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 Person centred care
- Regulation 11 Need for consent
- Regulation 12 Safe care and treatment
- Regulation 13 Safeguarding service users from abuse and improper treatment
- Regulation 15 Premises and equipment
- Regulation 17 Good governance
- Regulation 18 Staffing

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the service, and asked a range of other

organisations for information about this service. This information suggested that the rating of 'good' for responsive that we made following our June 2016 inspection, was still valid. Therefore, during this inspection, we focused on those issues that had caused us to rate the service as requires improvement for caring and inadequate for safe, effective and well led.

We also made some recommendations at the previous inspection which will be followed up at the next comprehensive inspection.

This inspection was unannounced, which meant the service did not know that we would be visiting.

# Summary of findings

During the inspection visit, the inspection team:

- visited two wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the interim manager and new manager for the Kedleston Unit
- spoke with 11 other staff members including doctors, nursing staff, a psychologist, a pharmacist and occupational therapists, assistants

- interviewed the Mental Health Act lead in the trust
- attended and observed one hand-over meeting and one Care Programme Approach (CPA) meeting
- looked at nine medicine records of patients
- carried out a specific check of the medicines management on two wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the provider's services say

Patients told us the food was all right and there was a variety.

Patients told us that the ward was always clean and tidy.

Patients told us the staff were nice.

Patients told us that staff supported them to learn new skills and in their recovery.

## Areas for improvement

### Action the provider **MUST** take to improve

- The trust must ensure that all patients are consistently provided with historical clinical risk management, version 3 risk assessments and that these are reviewed and updated to reflect changes in risks.
- All staff must receive basic life support training. Sufficient numbers of staff must receive intermediate life support training so there is a first aider on each shift.
- The trust must ensure that all staff receive training in and have an understanding of the Mental Health Act.
- The trust must ensure that all staff continue to receive training in and have an understanding of the Mental Capacity Act.

- The trust must ensure that patients are offered the opportunity to record their preferences in an advance directive.
- The trust must ensure that governance systems are robust.

### Action the provider **SHOULD** take to improve

- The trust should ensure that staffing levels are audited to ensure that managers know when escorted leave or ward activities are cancelled due to too few staff.
- The trust should ensure that doctors who are experienced in forensic psychiatry are available at all times.
- The trust should ensure that all staff receive regular supervision.

# Derbyshire Healthcare NHS Foundation Trust

## Forensic inpatient/secure wards

### Detailed findings

#### Locations inspected

##### Name of service (e.g. ward/unit/team)

Kedleston Unit

##### Name of CQC registered location

Kingsway site

#### Mental Health Act responsibilities

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

- All patients were detained at the unit under the Mental Health Act.
- Staff knew who the Mental Health Act administrators were and sought advice where needed.
- Staff had completed Section 17 leave paperwork correctly and this was up to date. Patients signed their leave forms and staff gave them a copy.
- The Mental Health Act e-learning training was being updated to ensure it met the Mental Health Act (1983) and its code of practice (2015), so it was not available to staff.
- The responsible clinician (doctor) obtained consent to treatment from patients in line with the requirements of the Mental Health Act and documented this on the authorised treatment certificate.
- The unit followed consent to treatment and capacity requirements and staff attached copies of authorised treatment certificate to medication charts. This meant that nurses were able to check medicines had been legally authorised before administering any medicines.
- Doctors requested second opinion approved doctors in a timely manner.
- Staff told us that patients were informed of their rights under the Mental Health Act on admission and every three months after. We saw this was recorded on the electronic records system. The form did not have a space to record when the patient refused to be informed of their rights. This meant it was not clear whether the patient was aware of their rights under the Act. We informed the trust of this and they agreed to amend the form.
- Information about the Mental Health Act was available on the ward to patients in different languages and in an easy read format.

# Detailed findings

- The service displayed information about independent mental health advocates on a notice board in each ward.
- We saw information displayed on each ward that showed patients they could complain to the care quality commission about their treatment under the Mental Health Act.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- At our last inspection in June 2016, we identified inaccuracies in the trust e-learning Mental Capacity Act training package. We also found that staff did not have a good knowledge and understanding of the Mental Capacity Act. During this inspection, we saw that the e-learning package had been updated to correct the inaccuracies. The Mental Health Act lead was to deliver face- to- face training in the Mental Capacity Act to staff on both wards in January 2017. Eleven staff had watched a clinical podcast with instructions and team discussion at a staff meeting in November 2016. The trust informed us that this had been supplemented by clinical audits which gave feedback to staff on their progress with direction on what to change about their practice and expected standards. The manager told us that this was to be further discussed during staff supervision to ensure the learning from this had been embedded.
- Three staff spoken with had a good understanding of the Mental Capacity Act, in particular the five statutory principles. Two staff spoken with did not show they had an understanding, for example, they told us that capacity could only be assessed by a doctor.
- The records for five patients who had impaired capacity did not show that capacity to consent to specific decisions about their care and welfare was assessed and recorded appropriately.
- We saw four records on the electronic records system that showed that the patient had the mental capacity to make the decision and they gave informed consent.
- We saw one best interest assessment that was detailed and in line with the five statutory principles of the Mental Capacity Act.
- All but one staff member knew where to get advice regarding the Mental Capacity Act within the trust.
- The trust had arrangements in place to monitor adherence to the Mental Capacity Act.

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

\* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

## Summary of findings

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

- At our previous inspection, seclusion facilities did not comply with standards set out in the Mental Health Act (1983) or the Code of Practice (2015). For example, there was no two-way communication and patients did not have access to toilet and bathroom facilities without going out of the seclusion room. In December 2016 work had begun on building a new seclusion unit, however, the one in use at the time of the inspection did not comply with standards set out in the Mental Health Act (1983) or the Code of Practice (2015).
- In June 2016, managers had not addressed all environmental risks, including ligature risks, identified through annual audit. In December 2016, ligature risks had been removed or reduced and action had been taken to create a safer environment for patients. The secure garden still included some items that could put patients at risk of harm, such as vermin bait boxes. However, the trust informed us that these did not contain poison. Staff supervised patients when they were using the garden.
- At our previous inspection, soft furnishings on Curzon ward were dirty, worn and threadbare on the arms of chairs. Fabric was torn in some places. In December 2016, new furniture had been ordered.
- In June 2016, low numbers of staff were up-to-date with basic life support and intermediate life support training. At this inspection only 74% of staff had received training in basic life support and 58% in intermediate life support. This meant there were not enough staff trained to ensure there was always a first aider on every shift.
- In June 2016, we found that completion of the historical clinical risk version 3 (HCR20v3) risk assessments was inconsistent; some patients had not been screened at all. This is a comprehensive set

of professional guidelines for the assessment and management of violence risk. In December 2016 we found that two of the 13 risk assessments had not been completed.

- However, we also found at our inspection in December 2016 that managers had not audited staffing levels to ensure they knew when escorted leave or ward activities are cancelled due to too few staff. This could mean that managers might not take action to action this.
- We also found that doctors experienced in forensic psychiatry were not available at all times.

However:

- The service had partly addressed the issues that had caused us to rate safe as inadequate following the June 2016 inspection.
- In June 2016, managers had not addressed all environmental risks, including ligature risks, identified through annual audit. In December 2016, ligature risks had been removed or reduced and action had been taken to create a safer environment for patients. The secure garden still included some items that could put patients at risk of harm, such as vermin bait boxes. However, the trust informed us that these did not contain poison. Staff supervised patients when they were using the garden.
- At our inspection in June 2016, records did not show that patients subject to restraint, seclusion or rapid tranquillisation medicine had been physically monitored by staff following any of these interventions. In December 2016, staff had recorded this.
- At our previous inspection, bank nursing staff were not always competent and up-to-date with 'control and restraint' training for managing violence and aggression. At this inspection we found that staffing levels were safe and most staff had received training in control and restraint.

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

- At our inspection in June 2016, the clinic room was cramped and cluttered and emergency equipment was not easily accessible. In December 2016, the clinic room was clean and organised.
- At our previous inspection there was not a clock visible from the seclusion room so that patients would be able to see the time. At this inspection, clocks were visible.

## Our findings

### Safe and clean environment

- Staff could not observe all parts of Scarsdale Ward because the nursing office did not overlook the ward and bedroom corridors were around blind corners. Staff told us there were plans to address this by the trust estates department. To reduce the risks to patients, staff positioned themselves around the ward and undertook observations of all parts of the ward. On Curzon Ward, the nursing office overlooked the ward so that staff had sight of the ward kitchen, the bedroom corridor and much of the lounge and dining room area.
- The risks of ligature points on the wards had been reassessed by the head of the trust estates department since our last inspection. Potential ligature risks had been identified and fittings had been changed in the bathrooms. The kitchens on both wards had been refurbished and the fencing in the garden that was left over from previous fencing had been removed. Potential ligature risks remained on the wards, including doors and door frames. The manager told us they were meeting with the head of trust estates and the trust safety and security lead the week after our inspection to discuss the plans for further work to reduce ligature risks. Ligature cutters were available in each ward office and all staff knew how to access these.
- The secure garden area was part of the daily security checks. Staff checked the inner and outer aspects of the perimeter fences twice a day to ensure the fence was intact and that patients could not climb the fence. They also checked that no restricted items, such as illicit substances, had been thrown over the fence from outside. The metal cigarette bin and the two large bins had been removed since our last inspection. However, the bait boxes for vermin remained in the garden. These could be used to secrete restricted items. Staff supervised patients when using the garden so these risks were reduced.
- The fully equipped clinic room was clean, tidy and organised. An air conditioning unit had been fitted since our last inspection. Staff undertook daily temperature checks of the clinic room and the medicines fridge. Records from November and up to the date of our inspection showed temperatures to be consistently within safe limits. Resuscitation equipment and emergency medicines were available and records we saw showed these were checked regularly and in date. Oxygen cylinders were stored safely. Bins to dispose of sharp objects were used appropriately and not over-full to reduce the risk of injury or cross infection.
- Seclusion facilities were located on Curzon Ward. At our previous inspection, we found the seclusion rooms were small and did not comply with the standards laid out in chapter 26 of the Mental Health Act Code of Practice. For example, there was no means of two – way communication, a clock was not visible from inside the room and toilet and bathroom facilities were outside the seclusion rooms. Since our previous inspection, work had begun on building a new seclusion suite to meet these standards. This work was on going at the time of this inspection and attention was paid to reduce the impact of these works on patients. This meant that the service was still temporarily using the old seclusion facility until works were completed. Clocks had been provided to help patients to know the time.
- Housekeeping staff were cleaning the wards during our inspection. Furniture on Scarsdale Ward was clean and in good condition. The soft furnishings on Curzon ward were dirty and torn, however, new furniture had been ordered. The kitchens, bathrooms and toilets were clean on both wards. The flooring of one shower room in Curzon Ward was stained. Staff told us they had tried to remove it but this was not possible as it seemed to be glue used when work was undertaken to the ceiling. Estates had been requested to replace this flooring.
- Staff followed infection control principles including hand washing. Staff received training in infection control. We saw that one hand gel dispenser was empty which could increase the risk of infection.

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

- Records showed that staff ensured equipment was well maintained and was tested regularly to ensure that it was safe to use.
- Managers undertook environmental risk assessments annually. Since our last inspection, the shed in the occupational therapy garden had been moved from the secure perimeter. This reduced the risk of patients climbing onto it to abscond.
- Staff had personal electronic alarms and a set of keys allocated to them at the start of their shift. Staff signed to say they had these. At the end of their shift they handed the keys back to reception staff and signed them out. During the evenings, a nurse was assigned to do this task. This meant that if any sets of keys went missing, reception staff could check who last had them. Staff we spoke with were aware of the system for keys and security.
- The sickness absence rate for November 2016 was 2.3% compared with the trust average of 5.0%.
- The manager told us that at night there were only six staff on the unit so the service needed to ensure that all staff working nights were trained in control and restraint. We saw that there were three nights in the five-week period where there was one staff member not trained in control and restraint and two shifts where there were only five staff on the unit. There were 11 shifts in the rotas we sampled where there was one staff member on one of the wards not trained to use control and restraint. Since our last inspection, the nurse bank had informed the ward which bank staff were competent in the trust's five day "control and restraint" training package for the management of violence and aggression and several bank staff had been trained in this.

## Safe staffing

- Managers calculated staffing requirements for the unit. The set nursing staffing levels on each ward were two registered nurses and two support workers for early and late shifts (7am to 2.30pm, 2pm to 9.30pm) and one registered nurse and two support workers at night (9pm to 7.15am). On days when there were no ward rounds, there was sometimes one registered nurse and three support workers on each ward for each shift.
- There was a vacancy for one registered nurse and two support workers. Interviews had been held for these posts and staff were due to start soon. In addition to this, two nurses who had recently completed their training (preceptors) were starting to work at the service from January 2017. Two staff told us that there were occasional shifts where they were short staffed, usually due to unplanned sickness. They said that the manager, who was not part of the staffing numbers, had covered these shifts so that safe staffing levels were maintained. Staff rotas we sampled for five weeks from 13 November 2016 to 17 December 2016 showed eighteen shifts that did not meet the set staffing level on one ward. However, there was always enough cover on the other ward, so on the unit as a whole, on those shifts. There was one shift in this period on Scarsdale Ward where there was only three staff (not the level of four) on shift and one of these staff members was not trained in control and restraint.
- Temporary staff used on the unit were regular bank staff. Many of these were Curzon and Scarsdale Wards' regular staff who also worked on the nurse bank. Occasionally, bank staff less familiar with the ward were used. These staff had an induction to the wards to orient them and the nurse in charge informed them of security procedures. In November 2016, there was 22% use of bank staff against a target of 5.0%. Agency staff was zero against a target of 2.0%.
- The manager was able to adjust staffing levels daily to take account of the needs of the patients. This meant that the manager could ensure that staffing levels were safe and met patients' needs.
- Patients had regular one to one time with their named nurse. This meant that patients had an opportunity to discuss any problems they had or to discuss how their treatment could be improved.
- Staff said they rarely cancelled escorted leave and scheduled ward activities due to too few staff; however, managers did not audit this.
- At our last inspection, we found that staff gender ratios were not always appropriate and sometimes there were mostly male staff on shift. At this inspection, we found that the ratio of male staff was 52% to 48% of female staff.
- Doctors on the ward provided medical cover from 9am to 5pm, Monday to Friday. A duty doctor provided out of

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

hours cover. However, this was sometimes provided by a doctor who was not experienced in forensic psychiatry. The doctor told us they tried to ensure any issues that might occur out of hours were discussed in the multidisciplinary team meetings on the ward to reduce any risk to patients. Patients were registered with a local GP. Patients received emergency medical treatment at the accident and emergency department at Derby Royal Infirmary.

- In November 2016, 90% of staff had received mandatory training. This exceeded the trust target of 85%. However, at the time of our inspection, only 74% of staff had completed the annual basic life support training and 58% had completed the intermediate life support training. Staff said this meant that a qualified first aider did not cover every shift.

## Assessing and managing risk to patients and staff

- We looked at the records for four patients. All included a detailed risk assessment. Since the last inspection, the tool used for risk screening had changed. Patients risks were now assessed using a safety plan, which staff reported was more collaborative and patient focused. We saw that it clearly showed patients' comments, thoughts and feelings and the reasoning behind the risk assessment. Staff reviewed these plans at each ward round and earlier if needed.
- At our last inspection, we found that only four patients had historical clinical risk management, version 3 (HCR-20V3) completed. This is a comprehensive set of professional guidelines for the assessment and management of violence risk. At this inspection, we found that two of 13 patients did not have a completed HCR-20V3 and this had been recognised by the multidisciplinary team in the meeting we observed. A further ten patients' HCR20V3 were waiting to be scanned into the electronic recording system. HCR20V3 risk assessments were reviewed for each patient every six months.
- Staff followed the trust policy for use of observation and each patient's observation level was discussed at their meeting with the multidisciplinary team.
- Staff used blanket restrictions only when justified based on identified risk. Patients were subject to a pat down search upon return from unescorted leave. Staff obtained consent from patients before searching them and this was recorded in their notes. Staff took patients on the ward to be searched. This meant there was a potential for risk items to be taken on the ward. Staff searched patients' bedrooms as per the random room search schedule. Additional searches of rooms were done by staff if there was a reason to believe the patient may have risk items in their room.
- Staff told us, and records showed that staff only used restraint after de-escalation had failed and using the correct techniques. Staff said that as most patients were there for a long time they knew them well and how to speak with them which helped them to calm down. Since our previous inspection, the trust policy on managing violence and aggression had been reviewed. One of the staff who was trained by the trust to deliver control and restraint training worked on the ward and helped to lead staff in de-escalation techniques. The manager told us that face down restraint was taught to be used only as a last resort in the control and restraint training. They said it had not been used in the time they had worked there which was just before our previous inspection. They said if it was used it would only be for a limited time.
- Pharmacists had audited the use of rapid tranquilisation since our last inspection and this showed that it had not been used. The rapid tranquilisation policy had been reviewed since our last inspection. The pharmacist had delivered some training sessions to staff informing them of the updated policy.
- There had been one episode of seclusion in the previous six months. Staff said the calming room (in the foyer area of the seclusion suite) was used more often but not seclusion. Since the previous inspection, the trust had printed off the seclusion policy for all staff to read and sign. We saw that staff had signed this. We did not look at seclusion records at this inspection.
- Staff were trained in safeguarding procedures and knew how to make a safeguarding alert. Since our previous inspection, the trust lead for safeguarding had changed. They had visited the ward, and updated staff in safeguarding procedures. Seven safeguarding referrals to the local authority were made in the previous six months. Most of these were patient-to-patient incidents which were not always reported in the past. This helped to ensure that patients were safeguarded from harm. During our inspection, one patient made an allegation

# Are services safe?

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to us about a member of staff. We told the new manager about this and they took action to ensure the patient was safe and reported the allegation appropriately. The patient had a care plan that showed they often made allegations which put them at risk of not being listened to. They had previously had two to one staffing to reduce the risks for the patient and staff. However, this was reduced at their previous multidisciplinary team meeting to one to one. The manager said they would discuss this with the patients named nurse and the multidisciplinary team to assess if their staffing ratio needed to be increased again. We looked at four safeguarding incidents, which showed that staff had a good understanding of safeguarding, how to report and follow up to ensure patients' safety.

- Staff managed medicines well. Medicines reconciliation, transport, storage, disposal and dispensing practices were good. Since our last inspection, an air conditioning unit was installed in the clinic room so that medicines were stored at safe temperatures. Medicine records were clear, signed, dated and recorded patients' allergies and sensitivities.
- Staff facilitated children visiting in a visitor's room separate to the wards.

## Track record on safety

- There have been no reported serious incidents for this core service since our last inspection.

## Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and did this consistently. The incidents were recorded on an electronic incident reporting system. These would go to the trust risk department, ward manager and lead nurses for them to review and say what action they had taken to minimise risks.
- Staff received feedback from the investigation of incidents, both internal and external to the service, at monthly staff meetings, registered nurse meetings, in clinical supervision and at handovers.
- The trust had a 'blue light' system (highlights changes and update in practice that all staff needs to know) on their intranet. This alerted staff through their emails to learning from incidents and about completion of incident forms.
- Staff told us of an incident between two patients where one patient was agitated and threatening to another patient. They had reduced these risks by asking one patient if they would like to eat their lunch on the other ward and this de-escalated the situation.
- Staff recorded any debriefs for staff and patients on the incident recording and reporting form. Staff and patients told us following an incident they were debriefed.

# Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Summary of findings

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

- At our inspection in June 2016, we found that staff understanding of mental capacity was poor. We found in December 2016 that some staff had not received training in and lacked understanding in the Mental Capacity Act.
- In June 2016 staff had not undertaken any formal assessments of mental capacity for any patients. At this inspection, staff had not appropriately completed assessments of patients' capacity to consent to decisions about their care and treatment.
- At our inspection in December 2016 we also found that non-medical staff had not received regular management or clinical supervision.

However:

- The service had partly addressed the issues that had caused us to rate effective as inadequate following the June 2016 inspection.
- At our inspection in June 2016, doctors had not consistently provided all patients with physical health assessments on admission. At this inspection, all patients had an assessment of their physical health completed on admission. Patients' physical health was monitored during their stay on the unit.
- At our previous inspection, patients' care plans were not personalised, holistic or recovery oriented. In December 2016, all patients' care plans we looked at were personalised, holistic and recovery oriented.
- In June 2016 doctors had not requested second opinion appointed doctors in a timely manner. This had improved at this inspection.
- At our previous inspection we found that Mental Health Act documentation was chaotically filed on the ward. This had improved at this inspection so that staff knew under which legal authority they were providing care and treatment.

## Our findings

### Assessment of needs and planning of care

- Before a patient was admitted, staff completed a preadmission assessment and this was discussed in the weekly referral meeting to ensure the unit could meet the patient's needs. We looked at four patient care records. These showed that a comprehensive and timely assessment was completed upon admission.
- Records showed that staff had undertaken a physical health examination of the patient on admission. Physical health care plans were detailed and showed ongoing monitoring of physical health problems. This was an improvement from our last inspection.
- Records contained up to date, personalised, holistic, recovery-oriented care plans. All care plans were reviewed and updated where needed at least monthly and sooner if required.
- Since our previous inspection, care records had been transferred from paper-based files to an electronic records system. All staff had access to these records.

### Best practice in treatment and care

- Staff followed national institute of health and care excellence guidance on rapid tranquilisation and subsequent health monitoring. This had been discussed with all staff so they knew what to do. This was an improvement from our previous inspection. There was evidence that doctors followed national institute of health and care excellence guidance when medicines were prescribed. Staff said they also followed the guidance on depression and on schizophrenia that was treatment resistant. Staff said managers expected them to follow the guidance when developing care plans, for example, where patients had psychosis or schizophrenia.
- Psychologists offered psychological therapies such as dialectal behaviour therapy and cognitive behaviour therapy as recommended by the national institute of health and care excellence. Patients had individual or group psychological therapy depending on their needs, preferences and suitability.
- Occupational therapists assessed patients using recognised assessment tools such as the model of

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human occupation screening tool. They then developed individualised activity schedules for patients to meet their identified needs. Staff used the Liverpool University neuroleptic side effect rating scale when prescribing anti-psychotic medication. This is a widely used self-assessment tool for measuring the side effects of antipsychotic medications. The pharmacist met with patients to discuss their prescribed medication and potential side effects.

- Patients' care records showed good access to physical healthcare, which was an improvement from our previous inspection. We saw physical health issues were discussed fully in multidisciplinary team meetings. Staff referred patients to specialist services where needed. We saw that where nicotine replacement strategies were offered to patients, they were assessed as to how this may affect their prescribed medication to ensure their physical health was not affected.
- Clinical staff and band 6 nurses undertook clinical audits such as care records, medicine charts and the clinic room. Since our previous inspection, a clinical lead had moved to the ward and part of their role was to support audits and care planning. We saw that audits had identified issues and the action needed to address these.
- The pharmacist participated in clinical audit for rapid tranquilisation, medicines management and storage and physical healthcare. The pharmacy technician visited the ward daily. The pharmacist visited weekly and attended ward rounds. They provided feedback to the nurse in charge, documented on patient records and gave verbal feedback to medicine prescribers.

## Skilled staff to deliver care

- The full range of mental health disciplines provided input to the unit. There was a consultant psychiatrist, occupational therapists, psychologists and a pharmacist. The same multidisciplinary team worked across both wards.
- Staff had an induction to the unit when they started working there.
- Staff had access to monthly team meetings. There was evidence of learning from when things went wrong in

the minutes of these meetings. We looked at the minutes of three meetings held since our previous inspection. This included discussion about the previous inspection and what action was being taken to improve.

- Of the non – medical staff, 93% had received an appraisal in the previous 12 months. This had improved from 84% at our previous inspection.
- Staff told us they received monthly supervision. However, figures given to us by the manager showed that at the time of our inspection 39% of non – medical staff had received monthly management supervision and 18% had received clinical supervision. The consultant psychiatrist told us they received regular clinical supervision and an annual appraisal.
- At November 2016, 90% of staff had received mandatory training. However, we identified that more staff needed basic and intermediate life support training. All regular staff and most of the regular bank staff had received control and restraint training. We saw that three of the registered nurses had organised a staff training day on person-centred care, which staff said they had benefitted from.
- The manager told us of how poor staff performance was addressed effectively. However, one of these issues had taken two years to address, which affected the service as it could not recruit a new member of staff during this time.

## Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings took place once a week on both wards. Patients were seen in the multidisciplinary team meeting once a fortnight with half the patients seen one week and the other half seen the next.
- If input was needed from speech and language therapists and social workers, referrals were made. Most of the patients had an assigned social worker who attended their multi-disciplinary meetings.
- We saw that the meeting was inclusive and collaborative. Patients were fully involved in the meeting. However, one patient sat in front of the screen that care plans and risk assessments were on which meant it was difficult for them to see this.

# Are services effective?

Requires improvement 

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- Nursing handovers were thorough and effective. Nurses handed over using the electronic care record system to provide up to-date, accurate information.
- Staff invited families and carers to care programme approach meetings and multidisciplinary team meetings with the consent of the patient.
- There was evidence of effective working relationships with care co-ordinators regarding discharge of patients.
- There was evidence of effective working relationships with the local authority safeguarding team. This was an improvement from our previous inspection.

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

- All patients were detained at the unit under the Mental Health Act.
- Staff knew who their Mental Health Act administrators were. Mental Health Act administrators offered support in making sure the Act was followed. Staff referred more complex issues to the trust's legal services manager.
- Section 17 leave paperwork had been completed correctly and was up-to-date. Patients' section 17 leave was reviewed at their multidisciplinary meeting. Records indicated that patients signed their leave forms and it was stated if they were given or had declined a copy. Risk assessments for section 17 leave were included in the patient's file. However, there was no photograph of the patient on their file. This meant that if the patient went missing during their leave there might be a delay in providing a current photograph to the police or other organisations.
- The Mental Health Act lead for the trust was updating the e-learning training to ensure it met the Mental Health Act (1983) and its code of practice (2015), so it was not available to staff. 85% of staff had received training in the Mental Health Act.
- The responsible clinician (doctor) obtained consent to treatment from patients in line with Mental Health Act requirements and this was documented on the authorised treatment certificate. The authorised treatment certificate for one patient was dated March

2015 and their section was renewed in May 2016. At this time the service should have notified CQC but they had not completed the relevant form. Staff completed this at the time of the inspection.

- Staff followed consent to treatment and capacity requirements and attached copies of authorised treatment certificate to medication charts. This meant that nurses were able to check medicines had been legally authorised before administering any medicines.
- Doctors requested second opinion approved doctors (SOAD) in a timely manner. This had improved since our last inspection.
- Staff told us that patients were informed of their rights under the Mental Health Act on admission and every three months after. We saw this was recorded on the electronic records system. The form did not have a space to record when the patient refused to be informed of their rights. This meant it was not clear whether the patient was aware of their rights under the Act. We informed the trust of this and they agreed to amend the form.
- Information about the Mental Health Act was available on the ward to patients in different languages and in an easy read format.
- Information about independent mental health advocates was displayed on a notice board in each ward. Staff told us that independent mental health advocates attended ward rounds for patients where appropriate. Since our previous inspection, the trust had made staff aware of the need to offer advocacy to patients in seclusion. Records showed that this was done in line with the code of practice.
- We saw information displayed on each ward that showed patients they could complain to the care quality commission about their treatment under the Mental Health Act.
- There were regular audits to ensure staff applied the Mental Health Act correctly. However, these audits had not identified the issues around forms for informing the patient of their rights and non-completion of forms to the care quality commission on renewal of a patient's section as highlighted above.

# Are services effective?

Requires improvement 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Good practice in applying the Mental Capacity Act

- At our previous inspection, we identified inaccuracies in the trust e-learning Mental Capacity Act training package. We also found that staff did not have a good knowledge and understanding of the Mental Capacity Act. At this inspection we saw the e-learning package had been updated to correct the inaccuracies. Face-to-face training in the Mental Capacity Act was due to be delivered to staff on both wards in January 2017. Eleven staff had watched a clinical podcast with instructions and team discussion at a staff meeting in November 2016. The trust informed us that this had been supplemented by clinical audits which gave feedback to staff on their progress with direction on what to change about their practice and expected standards. The manager told us that this was to be further discussed during staff supervision to ensure the learning from this had been embedded.
- We found a variation in staff knowledge and understanding of the Mental Capacity Act.
- There had been no deprivation of liberty applications made since our last inspection.
- We looked at the records for five patients. These did not show that staff had assessed and recorded patients' capacity to consent to specific decisions about their care and welfare appropriately. It was not clear in the assessment the reason why the decision that the patient did not have the capacity to consent was made. Three forms were incorrectly completed as they stated that the patient did not have an impairment of, or disturbance in the functioning of, the mind or brain when other records about the patient stated they did.
- We saw four records on the electronic records system that showed that the patient had the mental capacity to make the decision and they gave informed consent.
- We saw one best interest assessment that was detailed and in line with the five statutory principles of the Mental Capacity Act.
- Staff knew where to get advice regarding the Mental Capacity Act within the trust.
- There were arrangements in place to monitor adherence to the Mental Capacity Act within the trust. We met with the trust Mental Capacity Act lead during our inspection who showed us the updated training package.

# Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

## Summary of findings

We re-rated caring as **good** because:

- The service had addressed the issues that had caused us to rate caring as requires improvement following the June 2016 inspection.
- At our inspection in June 2016, patients' care records did not demonstrate that patients were actively involved in care planning and were not offered a copy. In December 2016, patients were involved in their care plan and staff offered them a copy of this.
- At our previous inspection, patients were not involved in service development. At this inspection, patients met fortnightly on the ward to discuss the running of the ward and service and what affected them.

However:

- In June 2016, we found that patients did not have advance directives in place. This remained outstanding at this inspection.

## Our findings

### Kindness, dignity, respect and support

- Throughout the inspection, we observed that staff were caring, kind and respectful of patients. In the ward round meeting we observed that staff had a good, engaging conversation with the patient and gave them the opportunity to speak.
- Patients told us the staff respected them and treated them well.
- Staff spoken with had an understanding of the individual needs of patients.
- Patient led assessment of the care environment scores relating to privacy, dignity and wellbeing were 94% for the Kingsway site where the Kedleston Unit was based. The trust average was 95% and the England average was 86%.

### The involvement of people in the care that they receive

- We looked at four patients' records. These showed that the patients were involved in planning their care and agreeing their goals. Staff asked patients if they wanted a copy of their plan and would like to sign it. They were given an opportunity to record their expectations, thoughts and feelings. Four patients told us they were involved in their care plan and had a copy.
- Patients told us that they met with their named nurse a few days before their ward round. This meant that they had a chance to think outside of the meeting about what they wanted and ensured their views were considered.
- We observed that patients were actively involved in their meeting with the multidisciplinary team. They were spoken with in a language they could understand and no jargon was used.
- Patients had access to advocacy services and information about these services was displayed on the wards. Two patients told us that an advocate had visited them.
- Staff offered families and carers the opportunity to be involved in care programme approach meetings where the patient consented to this.
- Since the last inspection, patients have had fortnightly meetings on the ward where they set the agenda. These were chaired by one of the nurses and minutes were kept. There were also daily morning meetings about what was going on that day and which patients had leave so that patients were kept informed.
- One of the patients told us about the patient magazine that they had been the editor for, called the 'Kedleston Times.' They said this was supported by the occupational therapist and was published twice in 2016. It had helped patients to maintain their IT skills following a course. The patient felt they had gained skills from this and hoped it would continue with a new editor.
- None of the patients we spoke with knew what an advance directive was. Staff said that none of the patients had these but now there was a Mental Health Act/Mental Capacity Act lead in post they would begin to work on them with patients. However, care plans for

## Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

managing the patients' behaviour showed staff asked them what triggered their behaviours and how they would like to be managed when they behaved in certain ways. For example, what would distract them and what activities would help them to behave in a way that was

less challenging. In addition to advance decisions about healthcare in the future, staff could ask patients to make advance statements about how they would respond when the patient behaved in certain ways.

# Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

## Our findings

# Are services well-led?

Requires improvement 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Summary of findings

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

- We found during our inspection in June 2016, governance process had failed to identify or protect people from unsafe care. Ward systems were not effective in ensuring that staff received mandatory training. Staff compliance with key training such as basic life support, intermediate life support and medicines management was low and did not meet trust expected targets. At this inspection we found governance systems had improved but had still not identified all the risks to the safety and welfare of patients. For example, staff had not received sufficient training in life support and the service had not reduced some of the environmental risks.

At our inspection in December 2016, we also found:

- Staff had not received regular supervision.
- The interim manager was due to return to their previous post and a new manager had started working at the service the week before our visit. Staff told us that management changes had affected their morale and they were unsure of the expectations of their role.

However:

- The service had partly addressed the issues that had caused us to rate well led as inadequate following the June 2016 inspection.
- At our previous inspection, staff did not know the trust's vision or values. Staff spoken with at this inspection were aware of these.
- At our inspection in June 2016, staff did not routinely monitor patients' physical health following the use of restrictive interventions and/or rapid tranquillisation. At this inspection staff monitored all patients' physical health needs.
- In June 2016, the trust policy governing the use of seclusion was inaccurate. There was under-reporting of the use of seclusion so it would not be possible for

the trust to be working on accurate data towards achieving their aspiration. The policy had been updated and reporting had improved at this inspection.

## Our findings

### Vision and values

- Staff were aware of the vision and values of the trust.
- Three staff told us that there was good team working and the objectives of the team reflected the values and objectives of the trust. However, another three staff told us that there were different objectives for each ward not for the unit as a whole.
- Staff knew who the most senior managers in the organisation were and told us they had visited the wards. Staff told us the area service manager was a visible presence on the wards and supported them well. However, some staff said that they did not think that the trust directors understood the risks of a low secure unit. They said that this affected the expectations of the trust and how the unit could meet these.

### Good governance

- At our last inspection we found that governance systems had failed to identify and protect patients from unsafe care. At this inspection, governance systems had improved and had identified some areas where improvements were needed:
- Staff participated actively in clinical audit and incidents were reported.
- Staff learnt from incidents, complaints and feedback from patients.
- Staff followed safeguarding procedures.
- The unit manager has sufficient authority and administrative support to do their job.
- Although the unit had planned to deliver staff training in basic and intermediate life support, this had not yet happened.

# Are services well-led?

Requires improvement 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- The trust planned to deliver updated training to staff in the Mental Health Act and Mental Capacity Act in January 2017.
- Records showed that staff had not received regular supervision.
- Staff training and understanding of the Mental Health Act and Mental Capacity Act was not embedded to ensure that these procedures were always followed.

## Leadership, morale and staff engagement

- There were no ongoing bullying and harassment cases.
- Staff knew how to use the whistle-blowing process.
- Staff told us they felt able to raise concerns without fear of victimisation. One staff member said they had raised concerns and were supported and empowered to do so.
- The unit had an improved management structure. Since our previous inspection a new clinical lead had joined providing further leadership. The interim manager had a handover period with the new manager before returning to their normal role. This meant the new manager was aware of the action plan and what needed to be done following our previous inspection. Staff told us that the manager changes had affected the team. They were not always sure what was expected of them as each manager made different changes. The new manager planned to organise a staff away day early in 2017.

- Staff told us that morale had improved; they felt listened to by the manager and were able to make changes to practice. They said there had been a lot of changes and they were looking forward to a more stable team. However, three staff said morale needed to improve and they did not always feel valued.
- Most staff spoke very positively about their team. They were proud of their team and supportive of one another.
- Staff were open and honest and explained to patients if something went wrong.
- Staff told us they could give feedback about the service in staff meetings. They could also go directly to the unit manager who welcomed their input.

## Commitment to quality improvement and innovation

- The unit was a member of the quality network for forensic mental health services (QNFMHHS). The manager and one nurse had attended the quality network annual forum in June 2016. They provided feedback to the staff meeting following this.
- The new manager had arranged a visit to a low secure independent hospital as there were no other services similar in the trust. They hoped this would improve the service and would encourage peer support opportunities.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

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

#### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

- Patients could not record their preferences in advance decisions.

This was a breach of Regulation 9 (1)(c)

#### Regulated activity

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

#### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

- Patients' capacity to consent to care and treatment had not been formally assessed and recorded when required.

This was a breach of Regulation 11 (1)(4)

#### Regulated activity

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

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- Two patients had not been provided with HCR20V3 risk assessments.
- Seclusion rooms did not meet the standards set out in the Mental Health Act Code of Practice 2015 and compromised the safety of staff and patients using them.
- Several staff had not received training in basic and intermediate life support.

This was a breach of Regulation 12(1)(2)(a)(b)(c)(d)

This section is primarily information for the provider

## Requirement notices

### Regulated activity

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

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- Governance systems did not identify all the risks relating to the health, safety and welfare of patients.
- This was a breach of Regulation 17 (2) (b)