Coventry and Warwickshire Partnership NHS Trust

Forensic inpatient or secure wards

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Forensic inpatient or secure wards

Inspected but not rated

We conducted an unannounced focused inspection of the forensic inpatient wards at Brooklands Hospital for people with a learning disability or autism. The purpose of the inspection was to find out whether the service was now compliant with the warning notice issued following the core service inspection in March 2023. The service was judged inadequate overall following the March 2023 inspection. The service did not meet the principles of Right Support, Right Care, Right Culture because:

• the service did not provide safe care

• the trust had not ensured staff adhered to the Mental Health Act Code of Practice in relation to long term segregation and seclusion practice. We were concerned the human rights of those in seclusion were potentially breached due to poor record keeping and governance

• staff were not conducting observations of people in accordance with their policy and the National Institute for Health and Care Excellence (NICE) guidance to protect people from harm

• the trust did not ensure the secure environment was fit for purpose and met the needs of people using the service

the trust did not ensure there were enough staff within the service to deliver safe, person-centred care

• the trust did not ensure staff caring for people are competent or trained for the environment in which they worked

• The trust did not ensure the governance of the service was effective in reducing and mitigating risk or improving quality for the people within their care.

Brooklands hospital is part of the learning disability and autism services delivered by Coventry and Warwickshire Partnership NHS Trust. There are 4 forensic inpatient wards based at Brooklands Hospital, these are:

• The Janet Shaw ward, a medium secure unit for adult men

• Eden ward, a low secure ward for adult women

• Malvern ward, a low secure ward for adult men

• Onyx unit, a newly opened purpose built low secure facility for up to 7 men with autistic spectrum disorder.

During our inspection, we visited all 4 wards.

We did not rate this service at this inspection.

How we carried out the inspection

Our findings

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection. We have reported in three of the five key questions; safe, caring, and well led. As this was a focused inspection, we looked at specific key lines of enquiry in line with actions required from the warning notice. Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report.

During the inspection visit, the inspection team:

• visited four wards at the hospital

• looked at the quality of the ward environment and observed how staff were caring for people

• observed one clinical review meeting

• observed 3 clinical activities

• spoke with 10 people who were using the service

• spoke with 3 carers of people who were using the service

• interviewed the ward managers of the wards

• spoke with 15 other staff members; including nurses, healthcare assistants, occupational therapist, clinical and security leads, associate practitioners, activity co ordinator, student nurses and housekeeping staff

• looked at 14 care and treatment records of people using the service Version 2b – 21 July 2021 3

• looked at 4 seclusion and 3 long term segregation records

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

What people who use the service say.

We spoke with 10 people at the service and 3 carers of people who were using the service.

Feedback from people was generally positive. Eight people said that they felt cared for, safe and staff were approachable. They also stated that they felt most staff knew them well and they were treated as individuals. We were told by 2 people that, although the use of agency staff was reducing, they felt these staff did not engage as much and often seemed disinterested.

We were told that there were plenty of activities on offer and people enjoyed attending the Brian Oliver centre which provided horticultural activities on site. All the people we spoke with, said the food on offer was variable. They said portion sizes were very small and they relied upon snacks they purchased to fill them up. We were told the menus were boring and repetitive and they really enjoyed cooking for themselves where possible.

Our findings

One carer we spoke with, was a member of the hospital carers forum which they enjoyed and had learned about medications and side effects that their loved ones may experience. They said the staff were very caring however the buildings were very tired and in need of updating.

We were told that the hospital did not allow visitors on the wards and visits had to take place at the Brian Oliver centre, this meant that people who did not have MHA (Mental Health Act) section 17 grounds leave could not see their loved ones in person.

Is the service safe?

Inspected but not rated

Safe care environments

At the inspection of this service in March 2023 we were concerned the trust was not ensuring the secure environment was fit for purpose and meeting the needs people in its care.

Managers had commissioned work to improve the environment on Janet Shaw ward; one wing of the ward had been vacated and contractors were on site. The work commenced one week before our inspection and was expected to be completed in 3 weeks. Rainbow ward was being used as an overspill area for long term segregation for 2 people from Janet Shaw ward. People from Rainbow ward was using the Onyx unit, a newly opened purpose built low secure facility for up to 7 men with autistic spectrum disorder. We inspected the environment which consisted of 7 apartments all of which had a lounge, dining kitchen, en- suite bedroom and private garden area.

Managers had appointed a security and restrictive practice lead since the last inspection. They informed us of the comprehensive programme of training for staff to increase competence and knowledge around security issues, for example, searching rooms and people, and undertaking and recording environmental safety checks. We found that environmental checks were recorded accurately on an electronic tablet.

Seclusion room

We looked at the seclusion rooms on Eden ward, Malvern ward and Onyx unit, all had two-way communication. However, the seclusion room on Eden ward did not have a clock or a bed base and the mattress was very thin, approximately 5cms thick and foldable which meant people would not have an even surface to lay on. Anyone with muscular skeletal issues would have difficulty both getting on and off the mattress, meaning the only place to sit in seclusion would be on the toilet. When we asked staff why there was not a typical seclusion bed in place, they said one person had placed a large semi rigid beanbag on top of the seclusion bed, climbed on top and then jumped sustaining a fractured arm. Managers decided to remove the seclusion mattress and replace it with the very thin alternative. We reviewed the recommendations following the investigation into this incident and found there were no directions instructing staff to remove the seclusion bed.

Safe staffing

Staffing levels had improved since the last inspection and vacancy rates across the wards were reducing. Qualified staff vacancy rates at the time of the inspection were 31% an improvement from 69% at the previous inspection.

Our findings

The levels of unqualified staff had increased and there were no healthcare support vacancies at the time of this inspection. The use of bank and agency staff remained at the same level as the previous inspection, this was due to high numbers of people on enhanced observation levels. We looked at staff rotas for the previous 2 months prior to the inspection and saw minimum staffing levels were achieved on most days. On the days where the wards were short staffed, managers and activity staff were included in the ward numbers this impacted on the number of activities offered. However, managers said the use of activity staff in the ward numbers had significantly reduced since our last inspection. Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift, they included bank and agency staff in protected learning time and reflective practice sessions with substantive staff. We spoke with 10 people using the service who all said leave or activities were occasionally cancelled, but were always rearranged, they said this was due to short staffing.

Mandatory training

At the inspection of this service in March 2023 we were concerned the trust was not ensuring staff caring for people were competent or trained for the environment in which they worked. We saw some improvement in mandatory training compliance rates, however the rates for resuscitation training were low at 37% on Eden ward and 58% on Onyx ward.

Safeguarding adults' level 3 was low with 67% completion on Onyx ward, 62% on Janet Shaw ward and 40% on Malvern ward, however staff we spoke with had a good knowledge safeguarding and described how they would identify and make a referral. Staff told us about the neurodevelopment liaison project and associated specific training opportunities for staff. The trust provided training in trauma informed care, recovery and wellbeing, sensory profiling, Oliver McGowan, and the Anna Freud autism courses, and 'making reasonable adjustments for people with autism' which was delivered alongside an expert by experience.

Managers on all 4 wards we inspected, provided all staff including bank and agency staff, with a monthly protected learning and reflective practice day. Staff confirmed this was appreciated and made them feel valued and increased their knowledge.

Assessing and managing risk to people and staff

At the inspection of this service in March 2023 we were concerned staff were not adhering to the Mental Health Act Code of Practice in relation to long term segregation and seclusion practice.

At this inspection we looked at 4 seclusion records and 3 long term segregation records in detail. We found 1 of the 4 seclusion records had been completed fully. On Janet Shaw ward we found no clear rationale to place a person into seclusion, staff said the person was agitated and at risk of self-harm. Staff used seclusion on Malvern ward as the person had been receiving threats from another person. We found staff had not recorded physical observations or food or fluids offered. Staff had not completed the seclusion audit tool for this episode.

On Eden ward staff secluded a person for 1hr 40mins and did not complete observations of the person throughout. Staff/ managers had not completed the seclusion audit tool for this episode. On Malvern ward staff did not record observations for one person in seclusion between 7am and 8am and the seclusion audit tool had not been completed

Our findings

for this episode of care. We looked at 3 long term segregation records. On Eden ward we reviewed the long-term segregation documentation for the last 3 months for one person. We found staff completing observation sheets were using their first name only and recorded minimal information about the persons presentation and interactions undertaken.

On Janet Shaw ward we saw staff moving one person to Rainbow ward long term segregation as the current environment was deemed inappropriate. We found that the person did not have an IMHA (independent mental health act advocate) and there was no evidence of a reintegration plan. The multi-disciplinary team had decided to move one person from long term segregation on Janet Shaw ward to long term segregation on Malvern ward. They recorded that this person must not mix with people on both wards. They also recorded that reintegration was not being considered at the current time due to risk to the people on both wards. The trust policy states “care plans should outline what is required of the person to do so that termination of long-term segregation is considered” we did not find any evidence of this. We noted that this person was under the care of a medium secure ward, however his long-term segregation was provided in a low secure setting. We did not see any evidence of how staff were managing the differing risk levels.

Management of peoples’ risk

Following the inspection in March 2023, we issued the trust with a Section 29A Warning Notice to make significant improvements to people’s observations, conducted in accordance with trust policy and National Institute for Health and Care Excellence (NICE) guidance to protect people from harm. Management and recording of people’s observation records had improved since the last inspection. We looked at 26 paper observation charts, the majority were fully completed with 4 gaps for 2 people on Eden ward which amounted to 4 hours in total.

Is the service caring?

Inspected but not rated

Involvement of people

We spoke with 10 people. One person had been at the hospital for 3 months and staff had not informed them how to access independent advocacy services, we brought this to the attention of managers who informed us they would ensure the person could access the advocate. We saw several examples whereby staff used different ways to communicate with people, including easy read versions of care plans and pictorial versions of activity timetables, posters, and information leaflets. People we spoke with said they enjoyed taking part in producing a monthly newsletter with the ward teams and this made them feel good.

Is the service well-led?

Inspected but not rated

Governance

Governance and monitoring processes had improved since our last inspection.

Our findings

Managers and clinicians chaired a monthly governance meeting with consultants, ward managers, multi-disciplinary leads, matrons, and the compliance manager. We reviewed the minutes from these meetings which included identifying staff training and development needs, quality reviews and security. The trust implemented a monthly matron's dashboard across the forensic service, which included data for clinical audits, incidents, safeguarding and seclusion.

Staff attended the learning from incidents group and fed back their findings to the ward teams. Ward managers completed a weekly audit which included people's physical health, staff supervision rates, long term segregation, cleanliness and hygiene, medicines management and review of the local risk register. Staff reported positive morale and spoke highly of the new senior management team.

Managers told us that senior staff were giving them more control, whereas previously they had to ask permission to get anything done. They also told us that there had been a reduction in micromanagement from the executive team and that senior managers were devolving decision making toward ward level

Our findings

Areas for improvement

Action the trust MUST take to improve:

• The trust must review the level of security required for a person in a low secure ward who was admitted to a medium secure ward.

• The trust must ensure seclusion records are fully completed every time a person is secluded.

Action the trust Should take to improve:

• The trust should review the use of a seclusion bed on Eden ward.

• The trust should review the use of visiting areas on wards where people do not have leave.

Our inspection team

The team that inspected the services comprised two CQC inspectors, one specialist advisor and one expert by experience. The team would like to thank all those who met and spoke with them during the inspection and who shared their experiences and perceptions of the quality of care and treatment at the hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment