Battersea Bridge House

Quality Report

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

Ratings

Overall rating for this location	**Good**
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

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

Summary of findings

Overall summary

We rated Battersea Bridge House as good because:

- The service supported patients' recovery by providing treatments recommended by national guidance. This included prescribing appropriate medicines, providing a comprehensive range of occupational therapy and providing psychological therapies. Patients had individual therapy sessions with a psychologist as needed and others attended group therapies.
- Patients said that staff treated them well. Patients described staff as nice, helpful and respectful. Patients were involved in decisions about their care and treatment. Patients met with staff every day in a relaxed and friendly environment to plan activities and groups for the day.
- Staff managed risks presented by patients well. All patients received a full risk assessment on admission, including a full risk assessment. Staff reviewed patients' risks every day and adjusted the level of restriction placed on each patient to reflect the risks they presented. The service had introduced a programme to reduce restrictive practices. This had resulted in the use of seclusion falling from 24 incidents in 2016 to eight incidents in 2018.
- The service provided care and treatment to patients in a clean and pleasant environment. All patients had their own bedroom with ensuite facilities. There were appropriate facilities available for patients' care and treatment.
- Patients had good access to physical healthcare. A GP visited the hospital at least once every two weeks. Staff referred patients to specialists when necessary. Staff completed regular health checks of patients receiving high doses of medication.
- The service employed experienced staff who were well supported through supervision, annual appraisals and team meetings. The service addressed poor performance appropriately.
- The service supported patients' discharge well. Staff planned patients' discharges over a number of months. Patients were granted leave to visit and stay at their new accommodation before the full discharge took place. Only one of the current patients had experienced delays to their discharge for non-clinical reasons.
- The service supported patients to engage in many activities in the local community to support their recovery. This included access to a choir, sports clubs and community cafes. Patients' feedback about these activities was very positive.
- The service had a structured system of governance that ensured staff and managers reviewed learning from incidents, safeguarding matters and complaints. The service had addressed concerns raised at our last inspection about ensuring there was oversight of patients' physical health, including the physical health of patients receiving high doses of medicines, and that the service notified the CQC of incidents. Staff felt the hospital director provided good leadership.

However,

- Some nurses and support workers said they did not feel listened to by the management team or involved in decisions about patients' care. Some members of staff said morale was low.
- There were some environmental risks such as poor sight lines on the wards and low risk potential ligature points that the service needed to address.
- The service had a high vacancy rate for registered nurses but all shifts were covered and the provider was recruiting to these posts.

Summary of findings

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Forensic inpatient or secure wards;

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Background to Battersea Bridge House

Battersea Bridge House is a hospital operated by Inmind Healthcare Group, an independent provider of mental health and social care services. Battersea Bridge House provides a low secure inpatient forensic service for men aged 18 years and over with severe mental illness and additional complex behaviour. The service has 22 beds and it provides services across three wards:

- Browning ward has 10 beds
- Hardy ward has six beds
- Blake ward has six beds

Twenty-one of the 22 beds were occupied during our inspection. All patients receiving care and treatment at the time of our inspection were detained under the Mental Health Act.

The service is registered to provide:

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

Battersea Bridge House registered with the CQC in December 2010. There have been six inspections. We inspected Battersea Bridge House in April 2017 when we rated the service as 'requires improvement' overall. Following the inspection in April 2017, we rated safe, caring, responsive and well-led as 'requires improvement', and effective as 'inadequate'. We carried out a further inspection in September 2017 that focused on the concerns we had raised earlier that year. At this inspection, we found that the service had addressed many of the concerns we had raised. However, we said that the service must make improvements to ensure the safety of patients receiving high dose medication. We also said the service must ensure that it notified the CQC of incidents when it was required to do so.

Our inspection team

The team that inspected the service comprised of four CQC inspectors, a Mental Health Act reviewer and a specialist advisor with a professional background of nursing within forensic mental health services

Why we carried out this inspection

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

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?

During the inspection visit, the inspection team:

- visited all the wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the services

Summary of this inspection

- spoke with the hospital director and the director of nursing for InMind
- spoke with 13 other staff members; including the clinical director, doctors, nurses, occupational therapists, a counselling psychologist and an assistant psychologist
- attended and observed a daily planning meeting and multidisciplinary handover meeting
- carried out a comprehensive review of the care and treatment records of three patients. We also looked at specific matters relating to treatment, medicines and the Mental Health Act on a further eight records
- carried out a specific check of the medication management
- carried out a review of how the service exercises its powers and discharges its duties conferred or imposed by the Mental Health Act in relation to the detention of patients
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Patients said staff treated them well and behaved appropriately towards them. Patients generally said the hospital was okay. All patients said they felt safe at the hospital. Most patients said the staff were nice, helpful and were respectful towards them. For example, one patient said that staff always helped if they needed anything. Patients spoke positively about the activities they did. All the patients said they had authorised leave from the hospital. Some patients told us about their plans for discharge.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The wards provided a pleasant environment for patients. The hospital was completing the final stages of refurbishment. Most ward areas were clean and well-maintained. Signs of wear and tear in some areas were being addressed through the refurbishment programme.
- The service managed the risks presented by patients well. Staff completed a risk assessment of all patients when they were admitted to the hospital. Staff reviewed patients' risks every day and adjusted the level of restriction placed on each patient to reflect the risks they presented.
- The service only imposed restrictions on all patients that were proportionate to the needs of maintaining security in a low-secure forensic environment. When staff imposed additional restrictions, such as restricting leave from the hospital or increasing observation levels, staff told patients the reasons for doing so.
- The service had introduced a programme to reduce restrictive interventions. The use of seclusion had fallen from 24 episodes in 2016 to eight episodes in 2018. Staff only used restraint after de-escalation had failed. Staff used rapid tranquilisation rarely and did so in accordance with national guidance.
- The service had appropriate systems in place to safeguard patients from abuse. Staff had completed training in safeguarding. Staff also had a good understanding of which patients were at risk of abuse and had developed plans to address these risks.
- The service had appropriate systems in place for the safe management of medicines. At our last inspection in September 2017, the service needed to improve systems for ensuring that staff completed physical health checks of patients receiving high doses of medication. At this inspection, we found that staff reviewed the side-effects of medicines and monitored the physical health of patients on high doses of medicines in accordance with national guidance.
- Staff reported incidents that occurred at the hospital. The hospital monitored trends and patterns of incidents that occurred. Staff held reflective practice sessions to discuss these incidents.

However,

Summary of this inspection

- There were some risks present in the ward environment. Some areas of the wards could not be observed easily by staff, and the service had not put in place plans to address these risks. Staff had not recorded some low risk ligature anchor points on the ligature risk assessment. There were sharp edges on the bed and window ledges in the seclusion room that could lead to patients injuring themselves.
- Staff had not responded when they found the temperature of the fridge used for storing medication had been slightly raised. This could compromise the effectiveness of the medicines. When we raised this matter, the hospital responded immediately.
- There were four vacancies for registered nurses out of an establishment of 11.
- The arrangements for storing information, using both electronic and paper systems, meant that it was not always easy to access information quickly. The use of paper records also meant that information that was more than six months old was stored in an archive away from the hospital site.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments of patients' mental and physical health when they were admitted. Staff created personalised and recovery orientated care plans that they updated each month. Care plans were written in a way that encouraged patients' ownership of the plan.
- The service provided care and treatment recommended by national guidance. The consultant forensic psychiatrist prescribed medication. Psychologists provided one-to-one therapy sessions for most patients, along with groups based on elements of cognitive behavioural therapy and person-centred therapy. Occupational therapists provided art therapy, yoga, music groups, cookery sessions and walks in the local community.
- Patients had good access to physical healthcare. A GP visited every two weeks. Referrals to specialists were made when necessary. Staff encouraged patients to live in a healthy way. A dietician had reviewed menus to improve the choice and quality of food.
- Staff had participated in clinical audits covering the use of seclusion, high dose medication, infection control and the use of the Mental Health Act.
- The service employed experienced staff across the appropriate professional disciplines. Staff received supervision and an

Summary of this inspection

annual appraisal. Appraisals included discussions about employees' overall performance, training and development and their future goals. The service dealt with poor performance appropriately.

- The service facilitated multidisciplinary and interagency team work. The service held effective multidisciplinary handover meetings each day to review each patients' progress and respond to changing needs. The service had good relationships with other agencies including commissioners, care co-ordinators and other forensic mental health service providers in the region.
- The service applied the Mental Health Act correctly and completed audits to check they were doing so. Staff supported patients to understand how the Mental Health Act applied to them and ensured that patients understood their rights to appeal.

However,

- Staff did not always complete care plans to address significant needs identified during the assessments. For example, one record did not include information to address identified risks of absconding. One of the six patients with diabetes did not have a care plan to show how their condition should be managed. Staff addressed these concerns during the inspection.
- We found that one patient was receiving a medicine that was not authorised by a second opinion appointed doctor when it should have been. We raised this during the inspection and the responsible clinician addressed this straight away.
- Staff did not always assess patients' capacity to make decisions in relation to specific matters. For example, staff had concluded that a patient did not have capacity to manage their own money without completing a formal assessment of the patient's capacity to do so.

Are services caring?

Good

We rated caring as good because:

- We observed positive interactions between staff and patients throughout the inspection. The atmosphere at the daily planning meeting was friendly and relaxed. Patients said staff treated them well and behaved appropriately towards them.
- Staff knew patients well. Staff had a good understanding of each patient's interests, their family circumstances and their plans for discharge. Staff were able to identify early indications of a decline in mental health for each patient.
- Patients were involved in making decisions about the service. Staff and patients met together each day to plan activities.

Summary of this inspection

Patients attended a community meeting each week at which patients discussed maintenance matters, feedback and suggestions. The service had completed a survey of patients' and carers' views and acted on the findings.

- The service involved families in patients care and treatment. Staff encouraged family members to attend care programme approach meetings. Family members also supported patients to have leave and participate in community activities.

Are services responsive?

Good

We rated responsive as good because:

- The service managed bed occupancy well. The service maintained an appropriate level of bed occupancy. The service did not admit new patients to bedrooms allocated to patients who were on leave. The service could transfer patients to hospital providing more intensive support and higher security if the patients mental health deteriorated.
- The service managed patients' discharges well. This usually involved planning over a number of months and facilitating patients leave to new accommodation prior to their full discharge. Discharge was rarely delayed other than for clinical reasons.
- The service provided appropriate facilities for patients' treatment and recovery. All patients had en-suite bedrooms. There were rooms on each ward that staff and patients used for groups and therapeutic activities. Patients had access to a small garden.
- The service supported patients to engage in many activities in the local community to support their recovery. This included access to a choir, sports clubs and community cafes. A local boxing club attended the hospital to run boxing courses for patients. Patients' feedback about these activities was very positive.
- The service investigated complaints and discussed feedback from these investigations with staff and the complainant. Where complaints were upheld, the service took action to prevent the concern arising again.

However,

- Patients had mixed views on the choice and quality of food. This included concerns about a lack of vegetarian, vegan and Caribbean food.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- Battersea Bridge House was a small hospital where all the staff knew each other. The leadership team visited the wards throughout the day and worked closely alongside staff. Leaders were experienced in working in forensic settings and had a good understanding of both the service and the individual patients.
- Feedback from staff in relation to the hospital director was positive. The hospital director had been in post for nine months. Staff said they found the hospital director approachable. Members of the occupational therapy and psychology team said they valued there being very little hierarchy at the hospital and this meant they could make decisions and improvements quickly.
- There was a clear framework for governance and decision making. The leadership team held governance meetings each month. The hospital director attended governance meetings at the company that owned the hospital every two months. Governance meetings reviewed complaints, learning from incidents and the risk register. At our last inspection in September 2017, we said the service must ensure there were sufficient governance systems to provide an oversight of clinical risks relating to patients' physical health. At this inspection, we found the service had addressed this.
- Staff collected data about key areas of service delivery and used this effectively to monitor trends and improvement performance. This data was clearly presented and reviewed at governance meetings.
- The service notified external bodies when it was required to do so.
- The service was a member of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services.

However,

- Some nurses and support workers said they did not feel listened to by the management team or involved in decisions about patients' care. Staff said there had been no review of their pay for over two years and that this was having a negative impact on staff morale.

Detailed findings from this inspection

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.

The service had appropriate systems in place to ensure that its responsibilities under the Mental Health Act (MHA) were carried out correctly. Eighty-two per cent of staff had completed mandatory training in Mental Health Law. Staff had a good understanding of the MHA, the Code of Practice and the guiding principles. The provider had relevant policies and procedures that reflected the most recent guidance. All records showed that staff had explained to patients how the MHA applied to them and their rights to appeal. The records showed whether the patient had understood that information. Three of the four records we reviewed showed that staff repeated this exercise once a month. Leave was monitored by staff and reviewed at daily multi-disciplinary team handover meetings. The service had completed a comprehensive MHA audit in January 2019.

However, during the inspection we found that medicine that was not authorised on the second opinion certificate had been dispensed to a patient. We raised this with the responsible clinician who addressed the matter immediately.

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had appropriate systems in place to ensure that its responsibilities under the Mental Capacity Act were carried out correctly. Ninety-seven per cent of staff had completed online training in the Mental Capacity Act. Staff took all practical steps to enable patients to make their own decisions. For example, staff helped patients to make decisions about managing their diabetes and taking medication in a supportive manner, helping patients to understand the options available to them and likely outcomes of these decisions. The service had arrangements to monitor adherence to the Mental Capacity Act, primarily through auditing capacity assessments within the Mental Health Act audit.

However, staff had not completed a mental capacity assessment for a patient who was considered unable to manage their money themselves.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Forensic inpatient or secure wards

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are forensic inpatient or secure wards safe?

Good

Safe and clean environment

Safety of the ward layout

Staff did regular risk assessments of the care environment. The service had completed an environmental risk assessment in February 2018. Staff completed environmental checks of the ward each day. Staff carried out an environmental check of patients' bedrooms once a week. A full fire safety risk assessment had been completed by an external health and safety contractor in February 2019.

Ward layouts did not allow staff to observe all parts of the wards. There were blind spots on all of the wards and CCTV was not routinely monitored. However, wards were small and there were no isolated areas. The service mitigated risks by ensuring staff were present on the wards at all times.

Staff had mitigated the risks of most potential ligature anchor points adequately. In September 2018, the service completed an assessment of risk for each individual patient with regards to risks associated with ligature anchor points. Staff reviewed the risk assessment for each patient at the patient's fortnightly ward round. Assessments showed that none of the current patients presented a high risk of self-harm using ligatures. If a patient did present a heightened risk, staff would increase the level of observation of that patient. The service had completed a ligature risk audit in February 2018. In response to the findings of this audit, the service had fitted anti-ligature wardrobe doors. However, the service had not completed some actions recommended in the audit, such as the replacement of taps in the main bathroom on Browning Ward. We also found door closers at the entrance to the patients' lounge on Browning Ward that could present a risk but were not recorded in the ligature risk audit. We noted that the risk presented was relatively low as the door closers were in a communal area of the ward.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff carried an alarm with them at all times. When staff activated an alarm, the location of the activated alarm was shown on a control panel in the nurses' office. The service had installed call buttons in all patients' bedrooms.

Maintenance, cleanliness and infection control

Most ward areas were clean, had good furnishings and were well-maintained. The hospital was in the final stages of completing a refurbishment. Refurbished areas were clean and well-maintained. Walls were painted in contemporary schemes. Furniture was clean and of a good quality. However, on Hardy Ward, an area of carpet next to where patients made drinks was dirty as a result of repeated spillages. The patients' kitchen on Hardy Ward had tiles missing and cracked kitchen units. Staff said that both these areas were due to be refurbished.

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. Domestic staff cleaned the communal areas of the ward each day. Patients' bedrooms were cleaned once a week. Daily cleaning records were present for all wards and were signed by domestic staff.

Good

Forensic inpatient or secure wards

Staff adhered to infection control principles, including handwashing. The service had completed an infection control audit in December 2018, covering hand hygiene, the ward environments, kitchen areas and disposal of waste. This audit showed the service was 92% compliant with infection control requirements.

Seclusion room

The seclusion room allowed clear observation and two-way communication, toilet facilities and a clock. The seclusion room was located on Blake Ward, on the ground floor of the building, but could be used by all the wards. There was evidence of recent refurbishments and improvements. For example, the service had recently fitted a new door. However, there were sharp corners on the bed and on a window ledge. Patients could have injured themselves on these edges. The seclusion room was also located on a bedroom corridor. This meant that the use of the room could disturb patients in nearby bedrooms. We raised these concerns with staff during the inspection. Staff explained that there was very little self-injurious behaviour in the current group of patients. Staff also said that the seclusion room was used infrequently. Records confirmed that the seclusion room had not been used in the five months prior to the inspection.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Records showed that staff on Blake and Hardy Ward checked the equipment each day. On Browning Ward, staff checked the resuscitation equipment each week. However, on Browning Ward, staff had recorded the fridge temperature as being slightly above the recommended range on six occasions between 1 and 20 February 2019. The hospital's policy stated that if staff found the temperature to be outside the recommended range, they should report the matter to the ward manager. Staff had reported the raised temperature on only one of the six occasions. No action had been taken. This meant that the quality and effectiveness of the medicines stored in the fridge could be compromised. We raised this matter with staff during the inspection. The service addressed the matter immediately by lowering the temperature of the fridge. Staff disposed of medication that had been stored in the fridge during that period.

Staff maintained equipment well and kept it clean. Staff did not record when they had cleaned the equipment, but during the inspection all equipment in the clinic room was visibly clean and well-maintained.

Safe staffing

Nursing staff

Between October 2017 and September 2018, staff sickness was recorded as 2%. Twenty-two staff had left the service during this period, giving a turnover rate of 49%. On the 31 October 2018, there were four vacancies for registered nurses out of an establishment of 11 nurses, giving a vacancy rate of 37%. Between 31 October 2018 and the inspection in February 2019, the service had filled all six vacancies for support workers.

Managers had calculated the number and grade of nurses and healthcare assistants required. The service used a modified version of the Safer Nursing Care Tool to calculate the number of staff required on each shift. The service allocated three registered nurses and six support workers to each day shift. At night, the service allocated three registered nurses and three support workers. Staffing numbers were allocated to the hospital as a whole. The service did not set specific staffing levels for each ward.

The number of nurses and healthcare assistants matched this number on all shifts. The service used bank and agency staff to cover absences due to sickness, leave and vacancies. Occasionally, managers were assigned to the wards to cover staff who were absent at short notice.

The ward manager could adjust staffing levels daily to take account of the case mix. Additional staff were allocated to the wards to cover enhanced observations for when there was a heightened level of acuity amongst patients.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. Between 31 August and 31 October 2018, the service had used bank staff to cover 359 shifts. The service had used agency staff to cover 404 shifts.

When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward. The service employed eight nurses and support workers on its bank. Permanent staff also carried out additional shifts as

part of the bank. The service tried to ensure it used the same agency staff on a regular basis. The induction for bank and agency staff covered security, fire safety, care planning, arrangements for patients' leave and medication.

A qualified nurse was present in communal areas of the ward most of the time. Two patients said there were always staff available although one patient said that there were times when there were no staff around. During the inspection, there were occasions on which there were no staff available on the ward. However, this tended to be at times when patients were engaged in structured activities with occupational therapists.

Staffing levels usually allowed patients to have regular one-to-one time with their named nurse. Staff allocated a primary nurse and an associate primary nurse to each patient. Primary nurses and associate primary nurses held one-to-one discussions with patients at least once a week.

Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. Patients and staff met together each morning to plan leave and activities for the day. On some occasions, leave was delayed due to staff having other commitments, but it was rarely cancelled. The service did not keep records of the number of times leave was delayed.

There were enough staff to carry out physical interventions (for example, observations, restraint and seclusion) safely and most staff had been trained to do so. On 30 September 2018, 75% of staff required to complete mandatory training on preventing and managing violence and aggression had done so.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The service employed a consultant forensic psychiatrist for four days each week and a full-time associate specialist doctor. The consultant, specialist doctor and another doctor who had previously worked at the hospital provided out-of-hours cover. The arrangements for cover were set out on a rota. All three doctors could attend the hospital within one hour of being called.

Mandatory training

Staff had received and were up to date with appropriate mandatory training. The service provided 24 training courses that were mandatory for all or some members of staff. These included health and safety, infection control, safeguarding adults and children, and immediate life support.

Overall, staff in this service had undertaken 89% of the training that the hospital had set as mandatory. Compliance with two courses was below 75%. Twelve out of 18 (67%) staff who were required to attend the medication awareness training had done so. Eighteen out of 32 (56%) staff who were required to attend breakaway training had done so.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed seven care records. We observed staff reviewing the risks each patient presented at the daily multidisciplinary team handover meeting and reviewed the hospital's risk monitoring tool. The service demonstrated good practice in all these areas.

Staff did a risk assessment of every patient on admission and updated it regularly, including after any incidents. All records showed that staff had completed a risk assessment when patients were admitted. One record showed that the risk assessment had been updated on eight occasions following incidents of verbal aggression and aggressive behaviour.

Staff used a recognised risk assessment tool. The service completed two risk assessment forms. Staff had developed a collaborative risk assessment form that they completed with the patient on admission and updated. Staff also completed a more formal historical risk management framework that is used across forensic mental health services in England. This framework provided a detailed risk history of each patient. The documents for the framework were updated at care programme approach meetings every six months.

Management of patient risk

Staff were aware of and dealt with any specific risk issues. For example, staff completed a bowel monitoring chart for a patient at high risk of constipation.

Staff identified and responded to changing risks to, or posed by, patients. Staff reviewed patients risks at daily multidisciplinary team (MDT) meetings, at fortnightly ward rounds and at six-monthly care programme approach

meetings. At daily MDT meetings, staff allocated patients a risk rating of red, amber or green. These ratings were displayed, along with other key patient information, on a white board in the meeting room. Staff adjusted patients' risk ratings based on their engagement with staff, compliance with medication, engagement in activities, and the patient's levels of irritability and aggression. During the inspection, two patients had a risk rating of red, seven had a risk rating of amber and 12 had a risk rating of green.

Staff followed good policies and procedures for use of observation and for searching patients or their bedrooms. The service set the observation levels for patients according to the risk the patient presented. During the inspection, 19 patients were on standard observations. This involved staff checking where the patient was every hour. Two patients were on enhanced observations. This involved staff checking the patient every 15 minutes. If a patient was known to present a risk of bringing prohibited items into the hospital, staff would search the patient when they returned from leave. Staff also searched the bedrooms of patients at risk of bringing prohibited items into the hospital. Staff carried out these searches at random or if there was reason to suspect the patient had prohibited items. Patients were always told that their room was being searched and were encouraged to be present during the search.

Staff usually applied blanket restrictions on patients' freedom only when justified. Blanket restrictions were proportionate to the needs of maintaining security in a low secure environment. For example, the service did not permit patients to bring alcohol or sharp objects onto the premises and doors to leave the building were locked at all times. The service only placed enhanced restrictions on patients if there was a specific need to do so.

Staff adhered to best practice in implementing a smoke-free policy. The service provided a smoke-free environment. Patients were offered nicotine replacement therapies including patches and gum. Patients could purchase e-cigarettes that were designed to be used safely in low secure environments.

Use of restrictive interventions

In the six months from 13 May 2018 to 12 November 2018, there were six episodes of seclusion. Three of these episodes involved a patient from Browning Ward. Three involved a patient from Blake Ward. At the time of the inspection, the service had not secluded any patients since September 2018.

In the six months from 13 May 2018 to 12 November 2018, there were 16 incidents of restraint involving five patients. On Browning Ward there were 13 incidents involving four patients. On Blake Ward there were three incidents, all involving the same patient. Nine incidents of restraint involved the use of the prone position. If prone restraint was used, staff had been taught techniques to transition away from that position as soon as possible.

The wards in this service participated in the provider's restrictive interventions reduction programme. The service had introduced a monitoring system to show the restrictive interventions for all patients at the hospital. For example, the system showed each patient as having a red, amber or green rating in relation to restrictive practices such as restrictions on leave, enhanced observations, searches and urinary drug screens. If a patient had a red or amber rating the system required staff to record the reasons for this. Staff shared this information with the patient. The service had also adopted a model of care that encouraged more therapeutic relationships and self-awareness among staff of the impact their actions has on patients. As part of this programme the service displayed information about the organisation's values and appointed a lead for least restrictive practices on each ward.

The service had significantly reduced the use of seclusion over the past two years. In 2016, staff used seclusion on 24 occasions. In 2017, staff used seclusion on six occasions and in 2018, staff used seclusion on eight occasions. Staff used seclusion appropriately and usually followed best practice when they did so. The service had completed an audit of the use of seclusion in August 2018. This audit covered six episodes of seclusion. The reason for seclusion was documented in all cases. Doctors were informed of the seclusion and attended to review the patient within an hour in all six cases. Records contained appropriate detail. Nursing reviews every two hours were completed in four of the six episodes. Doctors completed medical reviews every four hours in three of the six episodes.

Staff used restraint only after de-escalation had failed and used correct techniques. For example, when patients became agitated staff encouraged them to move to a quiet area of the ward, such as their bedroom. Staff also offered

patients medicine to help them calm down. When restraint was used, staff recorded the reason for the restraint, the type of restraint used and the names of the staff who had been involved.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Records of restraint included details of the circumstances that led up to the restraint. Records also demonstrated that when staff used force to restrain a patient, their actions were proportionate to the likelihood and seriousness of harm.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. In the six months from 13 May to 12 November 2018 there had been two incidents involving rapid tranquilisation. After staff administered rapid tranquilisation, staff placed the patient on enhanced observations and monitored the patient's vital signs.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. Eighty-five per cent of staff had completed mandatory training in safeguarding adults. Eighty-two per cent of staff had completed training in safeguarding children. Staff said that when they had concerns, they raised the matter with the nurse in charge.

Staff could give examples of how to protect patients from harassment and discrimination. Staff were aware of patients who were particularly vulnerable to financial abuse or exploitation and took action to address this. For example, staff strongly discouraged patients from swapping or trading clothes and other items as this could lead to disputes.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Managers discussed safeguarding with staff during supervision sessions to ensure staff knew what to do if patients were at risk. The social worker carried out the role of safeguarding lead for the hospital. They liaised with the local authority safeguarding team. Between January 2018 and January 2019, the service had raised 10 safeguarding concerns with the local authority. During that time, the service had also notified the Care Quality Commission of 21 incidents or allegations of abuse. Twelve incidents reported to the CQC involved altercations between patients. Notifications showed that the service took immediate action to address concerns to ensure patients' safety. For example, one notification related to a patient pressurising another patient to give them money. Staff spoke with the patient being pressured. Staff offered to arrange for this patient to move to another ward and helped him to ensure that his money and bank cards were kept in a safe. Staff also increased the observation level of the patient who had been asking for money.

Staff followed safe procedures for children visiting the ward. The service provided a family room outside the ward environment where children and young people under the age of 18 could visit patients. The hospital required children and young people under the age of 18 who visited patients to be accompanied by a parent or guardian.

Staff access to essential information

Most information was recorded on paper records. Some information was recorded on electronic documents and stored in the shared drive of the hospital's computer network.

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible format. However, the hospital only had space to store up to 12 months records for each patient. Older records were stored securely away from the hospital site.

Storing information on paper and electronically did cause staff some difficulty in accessing information. For example, it wasn't always clear whether information was missing or stored somewhere on the computer records.

Medicines management

Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal) and did it in line with national guidance. The hospital employed an independent pharmacy service. This included the dispensing of named-patient medication, provision of stock medication and medical information. A specialist clinical pharmacist visited the wards each week to review prescription charts and carry out a schedule of medicine management audits. The pharmacist met with clinical staff

and patients when necessary. All queries, errors, advice and audits were recorded in an electronic reporting system. The pharmacist also provided training on medication related topics.

Staff reviewed the effects of medication on patients' physical health regularly and in line with national guidance, especially when the patient was prescribed a high dose of antipsychotic medication. At our last inspection in September 2017, we found that staff had only completed physical health checks for three of the six patients receiving high doses of medication. At this inspection there were three patients receiving antipsychotic medication at a dose above the maximum dose stated in the British National Formulary. In order to monitor any adverse side-effects, the hospital carried out an electrocardiogram and blood tests on these patients every three months. Staff monitored these patients' pulse, respiration and blood pressure once a week. The hospital had completed an audit of the use of high dose medication in December 2018.

Track record on safety

There had been no serious incidents in the last 12 months.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Staff recorded incidents on an electronic incident reporting system. Staff gave examples of incidents they would report. These included aggressive behaviour, violence, destruction of property and verbal abuse.

Staff reported all incidents that they should report. Staff had recorded eight incidents on the electronic incident record. These incidents included a potential security breach, a safeguarding matter and a patient being admitted to the emergency department at the local hospital.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Senior staff described the service as being open, honest and transparent. For example, staff apologised to a patient following a medication error.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff discussed incidents at clinical governance meetings and handover meetings. The organisation maintained a learning log. This provided details of the learning from incident investigations at all hospitals run by InMind. Senior staff were aware of incidents at other hospitals.

There was evidence that staff made changes as a result of feedback. For example, analysis of incident reports found that there was a peak in the frequency of incidents in the early afternoon when there were fewer staff on the wards. This matter was discussed with staff at a governance meeting. Staff were encouraged to be more vigilant at this time.

Staff were debriefed and received support after incidents. Each ward also held reflective sessions for all staff to share learning from incidents. Staff held debriefing sessions after incidents. The hospital had introduced weekly reflective practice sessions for staff.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed seven care records during the inspection. All records demonstrated good practice in terms of assessment, treatment and risk management.

Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission. One record showed that staff had completed a comprehensive assessment on the day of admission. This assessment included details of the patient's presentation, mood and insight into their mental health condition. The assessment also provided details of the circumstances surrounding the patient's admission, details of medication the patient was taking and an initial care plan. The admission details for the other two records were stored in the hospital archive and were not accessible during the inspection.

Staff assessed patients' physical health needs in a timely manner after admission. Initial physical health

assessments included details of the patient's blood pressure, pulse, oxygen saturation, height, weight and allergies. These assessments also provided details of any long-term conditions.

Staff usually developed care plans that met the needs identified during assessments. Care plans included recovery goals specifically relating to risks and areas of concerns such as problematic drug and alcohol use. Care plans also included detailed lists of medication and therapy that were used to help patients improve their mental health. However, across all seven records we reviewed we found two specific matters that were not care planned. One record did not include any details of how the service was working to help the patient address their risks in relation to aggression and absconding. On another record, staff had not created a care plan to support the patient to manage their diabetes. We raised this matter with staff during the inspection and they addressed this immediately.

Care plans were personalised, holistic and recovery-oriented. The service used a structured care planning tool that were written in a way that encouraged patients' ownership of the plan. For example, they were titled "My mental health recovery", "Staying healthy" and "My life skills." These care plans included short-term and long-term goals for patients' recovery.

Staff updated care plans when necessary. Staff reviewed care plans collaboratively with patients once every month.

Best practice in treatment and care

We reviewed seven care records during the inspection. All records demonstrated good practice in terms of National Institute for Health and Care Excellence (NICE) guidance and rating scales.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). The diagnosis for most patients was schizophrenia. NICE recommends that for people with recurrent schizophrenia or psychosis, services should offer antipsychotic medication in conjunction with psychological interventions. The consultant forensic psychiatrist prescribed antipsychotic medication to patients. Just under half of the patients were prescribed clozapine. The counselling psychologist and assistant psychologist facilitated a programme of therapy to meet patients' specific needs. Fifteen of the 21 patients had one-to-one therapy sessions with a psychologist each week. Psychologists provided therapy based on elements of cognitive behavioural therapy and person-centred therapy. The service provided mindfulness groups for patients who did not wish to engage in one-to-one therapy or found it difficult to do so. Psychologists offered family therapy but none of the patients were receiving this at the time of the inspection. Occupational therapists provided art therapy, yoga, music groups, dancing sessions, cookery groups and walks in the local community.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. A GP attended the hospital at least once every two weeks. Staff accompanied patients to appointments with a dentist and to the local hospital. Six patients had diabetes. The staff supported patients to manage their condition in collaboration with the GP.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Speech and language therapists and dieticians had been involved in assessing and developing care plans to meet some patients' specific needs. A dietician had reviewed the menus in December 2018 and improved the choice and quality of food available.

Staff supported patients to live healthier lives. For example, through participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, screening for cancer, and dealing with issues relating to substance misuse. The service provided nicotine replacement therapies. The occupational therapist was supporting a patient to develop coping strategies to address their drug use. Staff encouraged patients to eat healthy food and provided access to a dietician to support this.

Staff used recognised rating scales to assess and record severity and outcomes. Staff recorded the scores of Health of the Nation Outcome Scales for each patient. Staff also gave a score from one to five to each area of patients care plans and updated this every six months. This enabled staff to measure the progress each patient had made.

Staff participated in clinical audits. Staff had completed audits to monitor the use of seclusion, high dose medication, infection control and the use of the Mental

Health Act. The service was not carrying out any specific quality improvement initiatives, although the quality of the service was being effectively monitored through clinical governance meetings.

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients on the ward. The service employed a consultant forensic psychiatrist, a specialist doctor, a counselling psychologist, an assistant psychologist, an occupational therapist, an assistant occupational therapist, a social worker, a director of clinical services (the lead nurse), a hospital director, nurses and support workers.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Staff at the hospital had experience of working in forensic mental health settings.

Managers provided new staff with appropriate induction. During their induction, staff were shown around the building, introduced to staff and given a safety briefing. The service had introduced an induction checklist to ensure that all new staff were aware of key information.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Between December 2017 and November 2018, compliance with the hospital requirements for supervision was 79%. We reviewed the supervision records of three members of staff. Records showed that they received supervision each month. Supervision records were brief, but demonstrated there had been some discussion about specific patients and safeguarding matters. In November 2018, 95% of staff had received an annual appraisal. Appraisals included discussions about employee's main duties, their overall performance, training and development and their future goals.

Managers ensured that staff had access to regular team meetings. There had been three team meetings in the two months prior to the inspection. Between 11 and 15 staff had attended each meeting. Managers used these meetings as an opportunity to talk to staff about their expectations in relation to specific aspects of care and treatment. For example, managers talked to staff about how to complete incident forms correctly, how to ensure that forms authorising patients' leave were completed correctly and to remind staff of the importance of completing monthly care plan reviews. There were some discussions about safeguarding matters that involved a risk to vulnerable patients.

The percentage of staff that had had an appraisal in the last 12 months was 95%.

The percentage of staff that received regular supervision was 79%.

Managers identified the learning needs of staff and provided some opportunities to develop their skills and knowledge. Staff discussed learning needs in supervision sessions. The focus of these discussions was on the completion of mandatory courses.

Managers ensured that staff received the necessary specialist training for their roles. For example, the psychologist had completed training in yoga. The assistant psychologist had completed training in restorative justice. The service appointed a registered learning disability nurse to lead the support for patients with intellectual impairments. The pharmacy service had provided some training on working with patients with diabetes.

Managers dealt with poor staff performance promptly and effectively. In the year prior to the inspection, the service took disciplinary action against five members of staff. The service had dismissed four members of staff. Prior to taking disciplinary action, managers raised concerns with staff in supervision sessions. During these sessions, managers explained their expectations to staff and set targets for improvement.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. The multidisciplinary team met to discuss each patient in detail every two weeks.

The ward teams had effective working relationships, including good handovers, with other relevant teams within the organisation. Nursing staff and support workers held handover meetings twice a day at the start of each shift. The multidisciplinary team held a daily handover to briefly review each patient and respond to any changes in each patient's presentation.

The hospital had effective working relationships with teams outside the organisation. The service had worked closely

with a consortium of forensic mental health service providers in the local region to provide additional bed capacity. The service also worked closely with its commissioners, NHS England. When patients were approaching discharge, the service worked closely with care co-ordinators, clinical commissioning groups and staff at the accommodation where patients were planning to move to. The occupational therapy team worked closely with community groups to enable patients to participate in community activities as part of their recovery.

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

Eighty-two percent of staff had completed mandatory training in Mental Health Law. Staff were trained in and had a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the MHA and its Code of Practice. Staff knew who their MHA administrators were. An MHA administrator was based at the hospital and was familiar with all the wards.

The provider had relevant policies and procedures that reflected the most recent guidance. The director of nursing was responsible for the MHA policies. The service had policies on different aspects of the MHA, such as a policy on the authorisation of patients' leave and a policy on ensuring patients understood how the MHA applied to them and their rights to appeal against detention.

Staff had easy access to local MHA policies and procedures and to the Code of Practice. These policies and procedures were stored on the hospitals' intranet that all staff had access to.

The provider had relevant policies and procedures that reflected the most recent guidance. An advocate attended the hospital at least every two weeks. In addition, the advocate was able to attend specific meetings with patients if requested.

Staff explained to patients their rights under the MHA in a way that they could understand, repeated it as required and recorded that they had done it. We reviewed the records of four patients. All records showed that staff had explained to patients how the MHA applied to them and their rights to appeal. The records showed whether the patient had understood the information. Three of the four records showed that staff repeated this exercise once a month.

Staff ensured that patients were able to take leave (permission for patients to leave hospital) when this had been granted. Responsible clinicians made decisions about authorising leave for patients at fortnightly multidisciplinary team (MDT) reviews. Leave was monitored by staff and reviewed at daily MDT handover meetings. If the responsible clinician did not authorise leave, they explained to the patient the reasons for this.

Staff usually requested an opinion from a second opinion appointed doctor when necessary. Twelve patients were receiving medicine authorised by a second opinion appointed doctor. However, during the inspection we found that medicine that was not authorised on the second opinion certificate had been dispensed to a patient. We raised this with the responsible clinician who addressed the matter immediately. Nine patients were giving consent to take their prescribed medicines.

Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them. All statutory documents relating to the MHA were stored in the MHA office.

Staff did regular audits to ensure that the MHA was being applied correctly and there was evidence of learning from those audits. The service had completed a comprehensive MHA audit in January 2019. Within this audit, staff checked 21 elements of MHA compliance on each record such as, the renewal date, the date of the last hearing, the last date on which staff spoke to patients about their rights, records of capacity assessments and date of certificates authorising medication. The audit found that staff had not assessed and recorded nine patients' capacity to consent to treatment in the last six months. The action plan following the audit was for the doctor to update these assessments.

Care plans did not specifically refer to identified section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising

Good

Forensic inpatient or secure wards

admission to hospital for treatment. However, care plans did include plans for discharge. The local authority's duties to provide aftercare services were discussed at care programme approach meetings.

Good practice in applying the Mental Capacity Act

Ninety-seven percent of staff had completed online training in the Mental Capacity Act (MCA). Most staff had a good understanding of the MCA, in particular the five statutory principles

There had been no deprivation of liberty safeguards applications made in the last 12 months to protect people without capacity to make decisions about their own care.

The provider had a policy on the MCA, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. The MCA policy was stored on the hospitals intranet that all staff had access to. The policy had been updated in September 2018.

Staff knew where to get advice from within the provider regarding the MCA, including deprivation of liberty safeguards. Staff in the MHA office could provide advice if required.

Staff took all practical steps to enable patients to make their own decisions. For example, staff helped patients to make decisions about managing their diabetes and taking medication in a supportive manner, helping patients to understand the options available to them and likely outcomes of these decisions.

For patients who might have impaired mental capacity, staff usually assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. The responsible clinician completed assessments of patients' capacity to consent to treatment. Records of these assessments included details of how the responsible clinician had reached their judgement. However, one patient was at risk of financial exploitation and staff said they did not have the ability to manage their own money. There were no assessments of the patient's capacity in relation to this matter.

The service had arrangements to monitor adherence to the MCA, primarily through auditing capacity assessments within the MHA audit.

Are forensic inpatient or secure wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. For example, there was a friendly and relaxed atmosphere in the planning meeting. At this meeting, patients and staff got on well together. We observed positive interactions between staff and patients throughout the inspection.

Staff supported patients to understand and manage their care, treatment or condition. Patients had regular one-to-one sessions with nurses to discuss their care and treatment. Patients said that staff had spoken to them about their medication. Patients could speak to the pharmacist directly if they wanted information about their medication.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, staff supported patients to engage in community activities such as sports groups and a community café.

Patients said staff treated them well and behaved appropriately towards them. Patients generally said the hospital was okay. All patients said they felt safe at the hospital. Most patients said the staff were nice, helpful and were respectful towards them. For example, one patient said that staff always helped if they needed anything. Patients spoke positively about activities they did.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Throughout the handover meeting and during our interviews with staff, staff demonstrated a very thorough understanding of their patients. For example, staff knew patients' family members who visited, staff knew how patients liked to spend time during the day, staff were able to identify early indications of a decline in each patient's mental health and staff were all familiar with patients' plans for discharge.

Good

Forensic inpatient or secure wards

Staff maintained the confidentiality of information about patients. Staff stored patients' records in a locked office. Staff did not discuss patients in communal areas of the hospital.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service. The service provided a well-presented welcome pack for patients, relatives and carers. The welcome pack provided information about the admission process, hospital routines, the staff team, patients' legal rights and details of the courses offered by the recovery college.

Staff involved patients in care planning and risk assessments. Some patients said they were involved in care planning and had a copy of their care plan. Some patients said they had met with commissioners and care co-ordinators to discuss arrangements for their discharge. One patient said that staff read through their care plan with them, but they were unsure about whether they were involved in preparing it. Evidence of patients' involvement in writing care plans was often limited to a few phrases stating the patients' views.

Staff communicated with patients so that they understood their care and treatment. For example, staff discussed patients care and treatment in one-to-one nursing sessions and when patients attended multidisciplinary team meetings.

Staff involved patients when appropriate in decisions about the service. At the start of each day, staff and patients met together for a planning meeting. At this meeting, staff offered patients activities that they could participate in during the day.

Staff enabled patients to give feedback on the service they received. In August 2018, the independent advocacy service facilitated a survey of patients' views. Six patients responded to this survey. The results of the survey showed that one patient was unhappy with the food. In response to this, a dietician revised the menus in consultation with patients. The service also held weekly community meetings. At these meetings, staff and patients discussed maintenance issues, feedback and suggestions about activities and courses available at the recovery college.

Staff ensured that patients could access advocacy. The service displayed contact details for the advocacy service on notice boards. An advocate visited the hospital every two weeks.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Some patients had families that were very supportive and regularly visited. Some family members were involved in supporting patients to have leave and participate in activities in the community. The service invited families and carers to attend care programme approach meetings and multidisciplinary team meetings.

Staff enabled families and carers to give feedback on the service they received. In October 2018, the service received six responses to a family and friends survey. Five of the six responses were positive. However, feedback from one family member stated that they had not been actively involved in the discharge planning of their relative. Following this feedback, the hospital has taken steps to ensure that, when patients give consent, all relatives are invited to meetings involving decisions about the patient's care pathway and progression.

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

Good

Access and discharge

Bed management

Between 1 June and 1 November 2018, bed occupancy on Blake Ward was 100%. Bed occupancy on Browning Ward was 81% and on Hardy Ward the figure was 84%. During the inspection, there were 21 patients at the hospital, giving a bed occupancy rate of 95%.

There was always a bed available when patients returned from leave. The service did not admit new patients to beds allocated to patients who were on overnight leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical

grounds and was in the interests of the patient. For example, a patient could be moved to another ward if there was a dispute between patients, but this would only happen if there were strong grounds for doing so.

When patients were moved or discharged, this happened at an appropriate time of day. The time of discharge was planned to ensure that the patient could be fully supported by the multidisciplinary team.

A bed was always available in a psychiatric intensive care unit (PICU) if a patient required more intensive care and this was sufficiently close for the patient to maintain contact with family and friends. In the year before the inspection, the service had transferred one patient to another hospital due to disruptive and violent behaviour caused by a deterioration in their mental health. The service transferred the patient to a medium secure unit in the same region.

Discharge and transfers of care

Staff planned for patients' discharge, including good liaison with care managers/co-ordinators. The service planned patients' discharges over a number of months. Usually this involved the patient visiting the proposed new accommodation for a number of days and having overnight leave to that accommodation before the full discharge.

Discharge was rarely delayed for other than clinical reasons. During the inspection, the discharge of one patient had been delayed. This patient had complex needs. The commissioners in their local area had found it difficult to find a placement for this patient where their complex needs and risks could be safely and appropriately managed.

Staff supported patients during referrals and transfers between services. For example, staff had supported a patient to attend the emergency department at the local hospital when they had become unwell.

Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms with en-suite facilities and were not expected to sleep in bed bays or dormitories.

Patients could personalise bedrooms. Patients had many personal possessions in their bedrooms. Patients displayed pictures, art work and photographs on their walls.

Patients had somewhere secure to store their possessions. Patients could store valuable possessions in trays in a locked cupboard. The service planned to install additional lockable storage facilities for patients as part of the refurbishment of the hospital.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. There were small clinic rooms on Browning and Blake Wards. There was a larger clinic room on Hardy Ward with an examination couch. There were a number of rooms for patient activities and a kitchen on Hardy Ward that could be used for occupational therapy.

There were quiet areas on the ward and a room where patients could meet visitors. The service had a dedicated family room away from the ward environment where patients could meet visitors.

Patients could make a phone call in private. The service provided a mobile telephone to patients. Patients could use these telephones to make calls and send text messages.

Patients had access to outside space. The service had a small garden with equipment for games and posts. Access to the garden was restricted to when staff were available to supervise. The service facilitated access at least three times each day.

Patients had mixed views about the quality of food. In December 2018, a dietician had reviewed the menus and introduced changes to the quality and variety of food available. Two patients said the food was good and meals were enjoyable. However, one patient said there was not enough choice of vegetarian or vegan food and that the quality of vegetarian options was poor. Another patient said the food was okay but they would like Caribbean food on the menu.

Patients could make hot drinks and snacks throughout the day and night. Staff provided flasks of hot water in the lounge areas so that patients could make hot drinks at any time.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. The hospital had created a recovery college that offered courses to patients in basic maths, English, typing and information technology. The service encouraged patients to participate in many

activities and groups in the local community. These included a community choir, a weekly sporting activities group, and a community mental health support group for patients from black and ethnic minority communities. Two patients had attended a national conference on mental health services. A local organisation attended the hospital to provide a programme of boxing classes for patients. Patients were very positive about these activities.

Staff supported patients to maintain contact with their families and carers. For example, staff authorised leave for patients to see their families and participate in activities with family members. Staff also supported patients to maintain contact with family members by email.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients. The ward could usually be accessed using a lift, although the lift was not working at the time of the inspection. The service had installed facilities on the staircases to ensure that any patients with impaired mobility could be evacuated safely. The service had completed an accessibility audit in February 2019. This audit noted that the keypad at the entrance to the hospital was not at a suitable height for a person in a wheelchair. The action recommended that the keypad was moved.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, how to complain. The service displayed information about the advocacy services, patients' rights and local services on notice boards. The pharmacy service provided patients with information about medicines if the patient asked for this.

The information provided was predominantly in a format accessible to the patient group. Information on some notice boards was only shown in standard formats. However, the service provided information about patients' rights under the Mental Health Act and the patients' welcome pack in accessible formats. Staff ensured that they read information to a patient who was unable to read themselves.

Staff made information leaflets available in languages spoken by patients. Staff could provide this information on request.

Managers ensured that staff and patients had easy access to interpreters and/or signers. Qualified interpreters and translators attended the hospital when required.

Patients usually had a choice of food to meet the dietary requirements of religious and ethnic groups. The service could provide Kosher, Halal and vegetarian meals. However, one patient said it was not clear how to request vegan meals. The staff addressed this matter during the inspection.

Staff ensured that patients had access to appropriate spiritual support. The service had recently created a multi-faith room within the hospital. This room provided a calm environment for reflection, contemplation and to observe religious practices. The service provided a list of religious and cultural organisations in the local area.

Listening to and learning from concerns and complaints

Between the 1 October 2017 and 30 September 2018, the service had received eight complaints. The service had upheld two complaints. One complaint had been partially upheld. The service had not upheld five complaints. None of these complaints had been referred to the Ombudsman. Two of these complaints were made by members of staff. These two complaints raised concerns about another member of staff.

Patients knew how to complain or raise concerns. The service displayed information about how to make a complaint on notice boards.

When patients complained or raised concerns, they received feedback. The hospital provided patients with a letter setting out the outcome of any investigations.

Staff knew how to handle complaints appropriately. The service assigned a senior member of staff to investigate each complaint. Following the investigation, a report was prepared and reviewed at the clinical governance meeting. Patients received a letter setting out a summary of the investigation and details of the outcome of the complaint.

Staff received feedback on the outcome of investigations into complaints and acted on the findings. For example, one complaint referred to a care programme approach (CPA) report being given to a patient's solicitor on the day

Good

Forensic inpatient or secure wards

of the CPA instead of being given in advance of the meeting. In response, the hospital changed its systems to ensure that reports were sent out in advance of all meetings.

Are forensic inpatient or secure wards well-led?

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. The hospital director, clinical director and consultant forensic psychiatrist carried out the main leadership roles. Each of these people had experience of working in similar services. The hospital director had extensive experience in forensic mental health services and had managed another hospital run by InMind. The clinical director had worked as a practice development nurse and led quality improvement initiatives in their previous roles.

Leaders had a good understanding of the services they managed. The leadership met as part of the multidisciplinary team each day for a handover meeting. This meant the leadership team had a good understanding of the service they managed. They also had a very good understanding of each patient using the service.

Leaders were visible in the service and approachable for patients and staff. Battersea Bridge House is a small hospital where all the staff work alongside each other. Leaders were present on the wards each day to speak with staff and patients.

Leadership development opportunities were available, including opportunities for staff below team manager level. At the team leader level, roles were being revised to give the post holders more responsibility. The service was creating one team leader role with responsibility for clinical matters and another team leader role to focus on operational matters. The service had also provided development opportunities for specific staff. For example, the assistant psychologist was responsible for collecting data and submitting reports as part of the commissioning for quality and innovation programme.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The hospital leadership said they put patients at the heart of the vision and values, enabling patients to be partners in decision making. This was reflected, for example, in staff's approach to restrictive practices. Staff always explained why a restrictive intervention was being used and sought the patients views on this. If it was, on reflection, felt that a restrictive practice had been used disproportionately, staff apologised.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. As Battersea Bridge House is a small hospital, managers had the opportunity to work alongside all their colleagues every day. Managers sought to communicate their vision and values by demonstrating kindness, compassion and care whenever they spoke with patients.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff participated in monthly team meetings where staff discussed many issues relating to the running of the service. However, some nurses and support workers said they did not feel listened to by managers.

Staff could explain how they were working to deliver high quality care within the budgets available. In order to manage financial pressure, the service was aiming to reduce spending on agency staff by recruiting permanent staff. The service was also working closely with other forensic mental health services to ensure that it received enough referrals.

Culture

Some staff felt respected, supported and valued. Over the previous two years, the service had been through a difficult period. A previous manager had been suspended and dismissed from their post. Another manager had left their post after a short period of time. Senior staff said that staff on the wards had found it difficult to make decisions and take the initiative in addressing concerns. The hospital director and clinical director said their priority was to develop a culture in which staff felt more empowered to make decisions. However, feedback from staff was mixed with staff in more senior roles being more positive. They commented that there was very little hierarchy and that being a small hospital meant that decisions could be made

quickly. In contrast, half of the ward based we spoke with felt they were not listened to by the management. We raised this concern with the directors. They said that support workers were now encouraged to attend multidisciplinary team meetings and to be more involved in decisions about patients, but they recognised that this initiative had only just begun.

Most staff felt positive and proud about working for the provider and their team. Staff in therapy roles described the hospital as a great place to work, but again, there were some ward staff who felt quite negative about the service. For example, two staff said there had been no review of pay for the past two years and that this was having a negative impact on staff morale.

Staff felt able to raise concerns without fear of retribution. Staff said they found the hospital director to be approachable and would have no fears about raising concerns. However, staff were not aware of a specific whistle blowing process. During the inspection, the CQC received an anonymous letter from a member of staff. This letter reflected the concerns relating to ward staff not feeling involved in decision making. After the inspection, the hospital informed the CQC that they had appointed a Speak Up Guardian and displayed information about how to contact the Speak Up Guardian around the hospital

Managers dealt with poor staff performance when needed. The service had been pro-active in addressing poor performance through the disciplinary process.

Teams worked well together and where there were difficulties managers dealt with them appropriately. Overall, staff had a lot of confidence in the hospital manager to address any difficulties.

Staff appraisals included conversations about career development and how it could be supported. All appraisal records included discussions about training and how to achieve goals for the future.

The service's staff sickness and absence were lower than the average for similar services. Between October 2017 and September 2018, staff sickness was recorded as 2%.

Governance

Overall, governance arrangements at the hospital worked well. During our last inspection in September 2017, we said that governance systems needed to be improved to ensure there was sufficient clinical oversight of risks relating to patients' physical health. We also said that governance systems needed to be improved in relation to staff understanding the Mental Capacity Act, medicines administration, updating risk assessments and learning from incidents at other hospitals. At this inspection we found that the service had addressed these matters. We found there were sufficient systems in place to ensure the hospital was clean, safe and well-maintained. The service was completing a refurbishment programme to improve the environment for patients. Whilst there was a significant number of vacancies for registered nurses, the service did ensure there were sufficient staff on duty. Staff comprehensively assessed patients and provided treatment in accordance with national guidance. Staff monitored each patient's progress each day and responded quickly to any change in the level of risk each patient presented. Staff received supervision. The service acted in accordance with the Mental Health Act. Staff reported incidents and discussed learning from investigations.

Battersea Bridge House is owned and managed by InMind, a private company that runs 10 hospitals for people with complex mental illnesses or personality disorders across England. The director of Battersea Bridge House met regularly with the chief executive and director of nursing of the company. The director also attended a bi-monthly company level corporate governance meeting. These meetings provided an opportunity for directors of all InMind hospitals to review incidents and share good practice.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The service provided monthly governance reports to InMind. The hospital held governance meetings every month. Between six and eight staff attended. At these meetings, staff discussed a standard set of agenda items covering incidents, data on restraints, fire safety, security, the risk register, safeguarding, audits, compliance and staffing. At each meeting, staff reviewed an action log to ensure the service was making progress on actions that had been agreed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. For example, following a complaint, the service improved its arrangements for sending information to patients' solicitors in a timely manner.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. The service had completed audits of medicines management (September 2018), consent to treatment (September 2018), high dose anti-psychotic treatment (October 2018), medication (October 2018), and rapid tranquilisation (September 2018). Additional audits related to the administration and prescribing of medication are completed by the pharmacist and reported each week.

Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients. For example, the service had met with providers of forensic mental health services in the area to discuss referral and discharge pathways.

Management of risk, issues and performance

Staff at ward level could escalate concerns when required. The main risk register was prepared at a corporate level covering risks across all InMind services. This included specific risks relating to each hospital. The risk register was reviewed at bi-monthly governance meetings. The hospital director could raise matters at those meetings for inclusion on the register.

Staff concerns matched those on the risk register. For example, the risk register included concerns about the level of staff vacancies.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. The plan included contact details for emergency services and a list of action staff should take in the event of an emergency.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. Some data was recorded during multidisciplinary meetings and handover meetings. Other data, such as information on the hours of meaningful activities offered to patients, was recorded by occupational therapists as a routine part of their work. The assistant psychologist collated this information in order to monitor performance and trends.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, most records were written into paper files, rather than being stored electronically. This meant that it was not always easy to find information or records that were more than six months old as these were stored in an archive away from the hospital.

Information governance systems included confidentiality of patient records. The service ensured that staff stored patients' records in filing cabinets in locked offices.

The hospital director had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement. The assistant psychologist collated information about the service and presented this to managers at governance meetings. This data was well presented. For example, the data on restrictive practices showed the level of restriction for all patients in relation to 16 potential restrictions. This data was presented on a single page, clearly showing the level of restriction in red, amber, and green.

Staff made notifications to external bodies as needed. The service was required to notify the Care Quality Commission (CQC) of incidents reported to the police, allegations of abuse and injuries to patients. At the last inspection in September 2017, we found the service had not notified the CQC of such incidents. We said that the service must do so. At this inspection, we found the service had addressed this matter. The service submitted statutory notifications to the CQC when required. The service notified the local authority of any safeguarding concerns. The service also notified other agencies as part of the multi-agency public protection arrangements when staff were planning the discharge of patients who were subject to these arrangements.

Engagement

Good

Forensic inpatient or secure wards

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. Battersea Bridge House was a small hospital. Senior staff had contact with ward staff and patients each day and were able to answer questions about the work of the hospital.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The service collected feedback questionnaires from patients and their carers. Patient and carers could also give feedback by speaking directly to staff.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Feedback was discussed each month in clinical governance meetings. The hospital displayed a notice board in reception showing how they had responded to comments from patients and carers.

Patients could be involved in decision making about changes to the service. Patients attended community meetings. At the meetings patients had made suggestions about new activities that could be provided, maintenance and house-keeping matters. The service user representative had agreed to attend monthly governance meetings.

Patients and staff could meet with members of the provider's senior leadership team. Members of the leadership team spoke with staff and patients each day.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. There had been some innovations at the service, such as introducing boxing classes for patients. The programme to reduce restrictive practices had also led to a significant reduction in the use of seclusion.

Wards participated in accreditation schemes relevant to the service and learned from them. The service was a member of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services.

Outstanding practice and areas for improvement

Outstanding practice

The service had worked hard to make links with community groups that provided support and activities for patients. These groups included a community choir, a community café and a sports group where patients played football once a week. A local boxing club provided boxing lessons to patients at the hospital. All these activities enabled patients to have regular contact with people from outside the hospital. Attending community groups meant that patients were engaging activities they could continue with after they left Battersea Bridge House and providing some continuity during the changes involved in moving to new accommodation. The feedback from patient about these activities was very positive.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The service should ensure that risks presented by poor visibility in some areas of the wards are addressed.
- The service should ensure that all potential ligature anchor points are recorded on the ligature risk assessment.
- The service should continue to recruit permanent staff to meet its establishment levels.
- The service should ensure that record keeping systems enable staff to access all the information they need about patients quickly.
- The service should ensure that risks presented by sharp corners on the bed and on the window ledge in the seclusion room are addressed.
- The service should ensure that staff inform their ward manager of any occasions on which fridge temperatures are outside the recommended range and take action to address this.
- The service should ensure that all staff are involved in decision making about patients and about the service.
- The service should ensure that it continues to monitor the food quality so that changes made by the dietician are still implemented effectively and feedback should be sought from patients.