Kent and Medway NHS and Social Care Partnership Trust

Forensic inpatient or secure wards

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Forensic inpatient or secure wards

Inspected but not rated

We expect health and social care providers to guarantee people with a learning disability and autistic people respect equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:

Model of Care and setting that maximises people's choice, control and independence

The unit was located on the outskirts of Dartford. It was local to amenities, shopping centres and other activities so that people could access the local community, both escorted and unescorted.

People had their own en-suite bedrooms on the ward with shared access to communal areas including living spaces and a dining room. People could personalise their rooms and staff had supported them with this.

The unit environment was clean and well maintained. The furniture was homely and welcoming and there were spaces on the ward for people to see visitors or spend time alone.

Staff supported people to improve their skills in working towards being more independent. Staff focused on people's strengths and promoted what they could do, so people had a fulfilling and meaningful everyday life.

People were supported by staff to pursue their interests and people said they had engaged in activities they had identified and enjoyed.

Staff worked with people to plan for when they experienced periods of distress and staff did everything they could to avoid restraining people.

Staff enabled people to access specialist health and social care support in the community. They supported people to attend dental, optician, and other physical health appointments.

Right Care:

Care is person-centred and promotes people's dignity, privacy and human rights

People received kind and compassionate care. Staff protected and respected people's privacy and dignity. People and their relatives said that staff looked after them well and treated them with respect.

Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. People told us they felt safe.

Our findings

People's care, treatment and support plans reflected their range of needs, and this promoted their wellbeing and quality of life.

Right Culture:

The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive, and empowered lives.

Staff knew and understood people well and were responsive, supporting their aspirations to live a quality life of their choosing. People and their relatives knew what their goals were and what their discharge plans entailed.

Staff placed people's wishes, needs, and rights at the heart of everything they did.

People and those important to them, including advocates, were involved in planning their care. Relatives told us they were invited to meetings and were kept updated by the family engagement and liaison lead.

Staff ensured risks of a closed culture were minimised so that people received support based on transparency, respect, and inclusivity. Staff were welcoming and the ward environment was calm and inviting.

People told us that leaders on the unit were visible and approachable. Staff used clinical and quality audits to evaluate the quality of care. Governance processes helped the service to keep people safe, protect their human rights and provide good care, support, and treatment.

Background to inspection

The Tarentfort Centre is a forensic inpatient learning disability secure unit with 20 beds.

The unit previously consisted of 2 wards, Riverhill and Marle, however, now consists of just one unit.

The unit cares for men over the age of 18. The unit specialises in the assessment and treatment of men with a learning disability and Autism whose offending behaviour and complex mental health needs require care in a low secure setting.

The unit consists of a multi-disciplinary team of health care assistants, nurses, occupational therapists, psychologists, a speech and language therapist, doctors, and consultants.

People are offered therapeutic activities by the occupational therapy team and their care is reviewed regularly during ward round and other multi-disciplinary team meetings.

CQC service type: Hospital services for people with mental health needs, learning disabilities and problems with substance misuse.

The location is registered to provide the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder, or injury

Our findings

Tarentfort Centre was previously considered under the core service of Wards for people with a Learning Disability and Autism, though due to commissioning changes since the last inspection, this centre is reported under forensic inpatient and secure ward core service.

We carried out an unannounced comprehensive inspection to the Tarentfort Unit following a number of notifications regarding sexual safety of the people living on the unit.

We inspected but did not rate the service because Tarentfort Centre is part of the larger forensic inpatient and secure wards and it would not be proportionate to re-rate forensic services based on the inspection of one ward.

Overall summary:

- The service provided safe care. The ward environments were safe and clean. The unit had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the people and in line with NICE guidance (National institute for Health Care and excellence) about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The unit teams included or had access to the full range of specialists required to meet the needs of people on the unit. Managers ensured that these staff received training, supervision, and appraisal. The unit staff worked well together as a multidisciplinary team and with those outside the unit who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients, families, and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well led and the governance processes ensured that unit procedures ran smoothly.

However:

- We saw that there had been an increase in incidents of a sexual nature. This was mainly identified as a specific individual person using the service, who is currently inappropriately placed at the Centre.
- The seclusion room door had a hinge that could be used to self-harm, it protruded out and was a potential for self-harm.
- People who lived on the unit told us that the food quality was poor.
- The electronic recording system was confusing and difficult to navigate although did not impact on staff finding information they needed.

What people who use the service say

People told us they felt safe on the unit, that they were able to find and speak to nursing staff if they needed to. They also said that there were other people in the staffing team they were able to speak to if they requested to.

Our findings

People told us they were treated with kindness and respect. One person told us the staff would have a laugh with them and this made it more fun to be on the unit.

One person told us that there was an attitude problem from some staff, and some of them were rude. He explained this saying staff asked him to stay away from other patients, he knew there was a risk issue in his care plan due to the sexualised behaviour he presented, but felt he wasn't spoken to appropriately. One person gave us an example of staff attitude was sometimes bad, and that they would say they would be back to talk to them but never returned. This was frustrating. Four of the ten people we spoke to said that the attitude was mostly from bank staff, and they felt that they did not spend the time getting to know them.

People said they can use the unit phone to contact friends and relatives, one person told us that this was hopeless as the landline was always down, but that they had been told this was being sorted. People told us that they had visits facilitated where possible.

People told us that they had a good range of activities and that the Occupational Therapist (OT), had a timetable for them.

People told us that they were able to have their own computer games in their rooms and these were risk assessed.

One person told us that the activities used to be poor, but that recently they had become better and more were available.

People told us they were allowed to have their rooms personalised with their own belongings and posters, but they had to be assessed that it was safe. They told us they had access to their rooms whenever they wanted to. One person told us his room was cold and the lighting was not working, but it was being sorted, otherwise he was very happy.

People told us that Section 17 leave usually took place, (this is a Section of the Mental Health Act (1983) which allows the Responsible Clinician (RC) to grant a detained patient leave of absence from hospital. It is the only legal means by which a detained patient may leave the hospital) to access the grounds, garden, and community. One person told us that if they were short on staff that the leave maybe affected, but it would be rearranged there and then. Three people told us they enjoy playing pool with the staff, and they enjoy going out to the local shops. One person told us he had a cooking session in the afternoon and was going out shopping to buy his ingredients, he told us he does this every week.

People told us there were morning meetings every Monday to Thursday and a community meeting on a Friday, where they were able to express concerns and make requests.

People told us there were trips to the cinema, local and wider community, and gym for those who had leave.

People told us that they were asked to be involved in their care planning and were offered a copy of this or that they could ask for a copy at any time.

People told us they knew how to contact the advocate and that they knew how to make a complaint. They said they felt comfortable talking to the unit manager and permanent staff about any issues they had. Three people told us they didn't feel that the bank staff listened to them so didn't feel confident about talking about their issues. One person told us that it can sometimes take a long time to get things sorted, like repairs.

Our findings

All patients were offered the chance to use the "traffic light system" which enabled them to use a colour coded card on their doors to inform the staff of how they were feeling. People said they felt comfortable with their cards on their doors. They said these were colour coded so staff knew what to do if the different colours were on the doors and people told us they felt happy with this as they didn't always feel they could speak to someone and needed quiet time and space. People told us this made them feel safer.

People told us the food was poor. One person said the puddings were not too bad, but the main meals were poor. One person told us he buys his own snacks as he prefers this to what is available.

People told us they were happy with their monthly MDT meetings and were able to speak to doctors or therapists in these meetings.

Is the service safe?

Inspected but not rated

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

There was a nurse on duty for each shift who maintained a safety checklist for all aspects of the environment.

There were detailed risk management plans for the unit, these were regularly updated, and recorded.

All risks were documented and managed by risk assessment and observations.

Staff were able to observe people in all parts of the unit and observation levels were implemented according to risk. CCTV was present and used only to view incidents.

The unit accommodated single sex people at all times.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe and this was all documented on the risk plan and the daily safety checklist, including the seclusion room door hinge. There were always 2 staff present for observations and if there was concern around self-harm then the seclusion would be terminated to mitigate this.

All staff were issued with alarms and keys at reception prior to the shift starting.

Maintenance, cleanliness, and infection control.

The unit was clean, tidy, well equipped, and well furnished.

The unit was well maintained and fit for purpose, with anti-ligature door furniture and equipment throughout all areas, with the exception of the Seclusion room door hinge.

Our findings

Staff were using infection control measures and there was plenty of hand sanitising points.

Seclusion room

The seclusion room allowed for clear observation, had a two-way communication system, and were fitted with a toilet and shower. A clock was visible. Water flow could be controlled from the observation area and power was also controlled from here.

The seclusion room door was a concern as it had a protruding hinge.

The seclusion room door was a self-closing door but we had concerns around the possibility of people wedging it open. Management were aware of this and were undertaking changes to make it safe. They assured us this would be done with immediate effect. The unit manager told us how they would cease the seclusion if they felt there was any danger to the individual from any self-harm.

Clinic room and equipment

The clinic rooms were clean, organised well and equipped with accessible resuscitation equipment and an emergency bag with emergency drugs which were checked weekly or after use if it had been required.

Emergency drugs were also checked weekly unless required and they would then be replaced immediately.

All equipment was checked daily and signed for.

All equipment was in date and PAT tested if required. Staff documented this in the clinic room book.

Safe staffing

Nursing staff

The service had enough nursing and medical staff, who knew the people and received basic training to keep people safe from avoidable harm.

The manager told us that there is a high level of bank staff used due to the levels of observations at times, but they are able to access the bank staff and find this safely covers the ward alongside the regular staff.

The rotas identified that during February 2023 there were 8 shifts not covered for Support Workers and 4 for Registered Nurses. In March 2023, there were 8 shifts not covered for Support Workers, but all Registered Nurses shifts were covered. Bank staff were used to fill these shifts. A total of 20 shifts over 2 months were filled by bank staff.

Managers calculated and reviewed the number of staff required to meet the needs of people on the unit. The unit manager had the authority to adjust these levels should they require additional staff at different grades, for example, if someone was going on home leave or out on a community trip, additional qualified staff maybe required and levels of supervision could increase, therefore the leave would go ahead with the manager adjusting the numbers accordingly. People on the ward told us there were occasions that leave may have to be cancelled, but they were given reassurance that the activity would be re-arranged and staff informed them as soon as they knew when this would be.

Our findings

The staffing consisted of 1 Nurse based on each side of the unit, and an additional nurse who worked across both sides of the unit. There were 7 support workers plus an additional 6 support workers to cover observations.

Current whole time equivalent vacancies were 2 x Registered Mental Health/Learning Disability Nurses and 3 x Health Care Assistants (HCA's)

The service had 1 band 7, 3 Band 6,8 Band 5, 10 Band 3 and 15.3 Band 2 staff full time employed.

The service did not use agency staff.

All bank staff used for unfilled shifts were given a full induction and were aware of people's needs and safety awareness on the ward, prior to starting their shifts.

There is currently a recruitment drive to fill vacancies which is being shared with the Brookfield Centre.

Managers supported staff who needed time off due to ill health and provided a gradual return to work programme if needed.

Sickness levels were low.

People who use the service told us that they received a regular one to one session with their nurse and with support workers.

Staff handover was efficient in managing information about people in the service, and they discussed all individuals during the handover meeting, including leave, risk, behaviour, and changes to their care plans or and risk assessments, visits, and activities.

Medical staff

The Service had enough medical staff during the day and at night. A doctor was able to attend the unit quickly if needed in an emergency.

Locum on call doctors were available and staff knew how to access these. Managers ensured that a full induction was given to locum staff and made sure they understood the service.

There was a Physical Health Nurse and doctor on site five days a week.

Mandatory training

Following the inspection we received further information clarifying that not all staff had undertaken or completed the Oliver McGowan training. or equivalent, staff had been made aware that the training was to be completed, but the staff are not compliant with the training.

Assessing and managing risk to patients and staff

Assessment of patient risk

Our findings

All people admitted to the unit had a full medical health check which was undertaken by the GP and any health risks identified at the point of admission.

Staff completed risk assessments using the Historical Clinical and Risk Management 20 (HCR-20) and the Short-Term Assessment of Risk and Treatability (START).

Staff completed detailed, thorough and individualised assessments.

Management of patient risk

Staff were made aware of any identified risks to the people and themselves. These were clearly reported in the morning handover meeting and recorded in both care plans and risk assessments.

Any changes to risks were discussed at the morning meeting so all staff were up to date with any changes in risk and changes to levels of observation.

Staff were able to observe people in all areas of the unit and outside garden area. Where it was not easy to observe this, staffing levels were increased accordingly to ensure safety was maintained at all times.

CCTV was installed on the unit, and this was only used for reviewing incidents, there was clear indication by each camera, to inform people and staff that the cameras were only ever used for reviewing and this was detailed in words, pictures, and easy read. There was a clear detailed policy for the use of CCTV. Staff were aware of this and where to find it.

Security searches were carried out on people following unescorted leave. Staff also told us that they carried out random searches on people's bedrooms as per their policy and additionally if there were concerns.

All patients had a snapshot Positive Behaviour Support plan identifying any immediate behavioural risks, and these were detailed, person centred and informative for staff and patients. These were in written format and easy read, if required.

Use of restrictive interventions

The service had a reducing restrictive practice meeting which was attended by the unit manager. Local governance and wider governance processes ensured that any incidents of restraint and seclusion were appropriately monitored and reviewed. The trust had a Restrictive Practice policy in place which was up to date and which staff were following. Security searches were carried out on people following unescorted leave. Staff also told us that they carried out random searches on people's bedrooms as per their policy and additionally if there were concerns.

Staff undertook the service's least restrictive interventions training as part of their induction training and this met the best practice standards, was reviewed regularly, and updated if needed.

Staff were aware of how to use least restrictive interventions and were clear on the fact that they would always use verbal de-escalation to minimise risk and keep people safe. They would only ever implement the use of physical restraint or seclusion to ensure that the patient and others remained safe.

Our findings

Staff were aware of the Mental Capacity Act (MHA) definition of restraint and worked within its parameters. No issues were raised from the Mental Health Act visit on 29th March 2023.

Rapid Tranquilisation (RT Intra-muscular injections for the management of severe agitation and aggression) had not been used on the unit recently and staff informed us these were only used as a last resort.

Patients who required seclusion were treated with kindness and respect and only remained in the seclusion area for the minimum time required to ensure risk had reduced and safety of themselves and others was no longer at risk.

Staff ensured best practice was used during the seclusion timeframe. Records were clear, detailed, and the correct physical observations were made throughout and recorded. There were 2 seclusion incidents following violence and aggression, in the last 3 months.

There had been no record of long-term segregation within the last 6 months, although staff were aware of the process, they had to follow in the required timeframes of doctors' visits, health checks, nutrition, and fluid requirements, and how to document this.

Staff had recorded 3 restraint incidents, in the last four months all of which demonstrated the use of decreasing holds, more emphasis on verbal de-escalation, and a quicker resolution to the immediate behaviours.

Safeguarding

All staff received training on Safeguarding, how to recognise abuse and how to report it.

Staff compliance with induction safeguarding training was 100%, Safeguarding Adults level 2 (3yearly) 90.91%, Safeguarding Adults level 3 (3 yearly) 90.91%, Safeguarding Children (yearly) 93.94%. The service's target was 90% compliance, so their targets were all met.

Alerts were sent to staff when their updated training was required.

Staff followed clear procedures to keep children visiting the ward safe. Staff worked with the person if a child were to visit and assessed if there were likely to be any safety issues. These visits usually took place at another building off the main ward site. Family members had access to the non-patient areas for visits in the family room, and on occasions either risk was assessed as being high, or families had requested, the visit would take place with the door open and a staff member outside, but this was well planned and documented and agreed by all people concerned with the visit including the families.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Most staff we spoke with gave examples of safeguarding concerns and told us that although they had not had to make any safeguarding referrals, they knew how to if they needed to. Any staff member was able to make a referral. The manager informed us of a safeguarding which had been made and the actions taken to reduce risk, this was managed by moving the patient from one side of the ward to the other, away from the risk, and had a positive outcome.

Staff access to essential information

Our findings

Patients care records highlighted the support they needed and staff kept high quality clinical and care records. Staff kept accurate, complete, legible, and up-to-date records, and stored them securely on the electronic recording system. Although the information was detailed on the system, it was not always easy to navigate around the system, we found various information documents in a number of places within the system which was time consuming and could be confusing. Managers assured us that this was an issue they were currently looking into changing to ensure easier access.

All staff could access people's records which were all on a password protected electronic recording system and staff accessed information governance training yearly as a mandatory training item.

When patients were transferred out of the service there were well documented plans and pathways which were relayed to the receiving service via meetings and written documents which were individualised and person centred.

Although there were some people experiencing delayed discharge, the service was working hard to identify and secure appropriate placements for the patients. There was a fortnightly system wide discharge planning meeting called 'Homes not Hospitals' where people's discharge was discussed regularly, and leaders raised any system delays with commissioners. People told us that their discharge plans were regularly discussed at their ward rounds and Care Programme Approach (CPA) meetings.

Social Workers and community teams were involved in this process along with the Learning Disability Forensic Outreach Liaison Service (LDFOLS), Multi Agency Public Protection Arrangements (MAPPA), and Police liaison officers.

Medicines Management

Staff followed systems and processes when safely prescribing, administering, and recording medicines.

Staff used an electronic system to prescribe and record the administration of medicines. They also used another electronic system to document patients' notes.

The pharmacy department provided expert clinical advice to prescribers and staff. They supported the safe and effective use of medicines including reviewing and reducing prescribed medicines in line with the STOMP (stopping over medication of people with a learning disability, autism or both with psychotropic medicines) principles. They also ensured additional monitoring and safety considerations were being followed prior to a medicine being administered.

Medicines were dispensed by an independent pharmacy contractor and sent to the ward twice a week. If medicines support was required out of hours there was an on-call pharmacy service. Access to medicines outside of normal times could be obtained by emergency drugs cabinets that also included prescriptions that could be taken to community pharmacies if needed.

Mental Health Act consent to treatment documents were in place in the clinic rooms and were being followed. Staff could check these against what they were administering.

Access to medicines storage areas was appropriately restricted. Staff had access to diagnostic equipment to support them to care for people.

Staff had access to emergency equipment including emergency medicines. These were checked regularly by staff.

Staff had access to medicines disposal facilities and any disposed of medicines were recorded appropriately.

Our findings

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.

Pharmacy staff attended ward rounds where patient's care, including prescribed medicines, were discussed with a multidisciplinary team. We saw evidence of regular reviews of people's prescribed medicines and an active drive to remove unnecessary restrictive medicines.

People were actively involved in making decisions about their medicines where this was appropriate. Staff worked with patients to balance clinical effect and side effects to find a treatment that worked best for individual patients.

Staff always had access to advice from a clinical pharmacist when needed.

Staff working out of hours could access the trust on-call pharmacy service for medicines advice or additional supplies.

The pharmacy team conducted a number of different audits and reviews which included medicines management, controlled drugs and the POMH-UK (Prescribing of antipsychotic medication in adult mental health services) audits. Learning from these audits were shared with staff on the wards and action plans put into place where practice could be improved.

Staff took appropriate action to safeguard patients' safety and monitor the effects of their medicines on them.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy.

Medicines were all stored in locked cabinets. Access to this was limited to authorised staff only.

Temperatures for the room, cabinets and medicine fridges were taken daily by staff.

Where medical gases were stored these were secured and in date.

Staff followed current national practice/guidance to check patients had the correct medicines.

Pharmacy technicians or pharmacists would attend the ward and complete a full medicines reconciliation (the process of accurately listing a person's medicines) within 24 hours of admission to a ward during normal working hours. The trust monitored compliance with this target.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Medicines incidents were reported using an electronic system.

Learning from incidents would be shared by the trust to staff so that improvements to practice could be made.

The trust had a system to manage and act on medicines safely alerts and recalls.

There were no fire risk assessments in place for those people prescribed paraffin-based skin products.

Our findings

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Intramuscular rapid tranquilisation (RT) was rarely used on the ward and there was a process which was followed to make sure it was only used as a last resort. Whilst RT had not been used recently, staff were able to provide us with assurances that they understood how to use it safely and the process that had to be followed if RT was administered.

Use of 'when required' (PRN) medicines to manage agitation and aggression on the wards was consistent with the need of the patients there when recorded. Whenever possible, de-escalation would avoid using a PRN medicine with comprehensive behavioural support plans in place that were made with the help of the patient and the psychology team.

When some PRN medicines were administered staff had not recorded clearly in the progress notes about why the decision was made to administer a medicine or if it had been effective. Without this information we could not always be assured that PRN medicines were being used appropriately.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Staff ensured each persons' physical health was monitored regularly. There was a physical health lead nurse who supported staff with managing and monitoring patient's physical health needs whilst on the wards.

Each patient had access to an independent GP service which would also support patient's medical needs on the wards.

Any medicines or treatment regimens that required additional monitoring had these carried out within the required timeframe.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff were able to identify what incidents were and how to report them. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff understood the duty of candour and were open and transparent to patients and families when things went wrong. One family member we spoke to confirmed that they and their family member had been spoken to by staff and given a clear explanation of what had gone wrong, how the service were managing it and regular updates when needed or requested. Support was given to all parties concerned and recorded in the daily notes. Staff told us they were supported with a team or individual debriefing following a serious incident.

The service also used restorative practice to help manage conflict and resolve incidents on the ward. Restorative practice brings those harmed by conflict and those responsible for the harm into communication, enabling everyone affected by a particular incident to play a part in repairing the harm and finding a positive way forward. Leaders told us that they had been accredited for their work in using this within the healthcare setting.

Our findings

The service recorded any use of restrictions on people's freedom, and managers reviewed use of restrictions to look for ways to reduce them. Managers held a blanket restrictions assessment and log which was reviewed regularly by the ward manager and responsible clinician.

Lessons learned were shared across the wider service.

The service had no never events (Never Events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented) on any wards.

Incidents that were reported were well documented and the manager kept a spreadsheet of what the incident was, how it was managed, by whom and what the outcome was. This was then followed up with a lessons learned process delivered by managers to staff.

Is the service effective?

Inspected but not rated

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We saw evidence of this in all files we reviewed.

All patients had their physical health assessed soon after admission and regularly reviewed by the Physical Health Nurse and doctor during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. These were person centred, needs led, personalised and holistic in value.

All patients were offered the chance to use the "traffic light system" which enabled them to use a colour coded card on their doors to inform the staff of how they were feeling, green, indicated they were feeling fine and didn't need any intervention currently. Amber, indicated they needed staff to knock on their door and check in with them if they needed some help or support. Red indicated they needed someone to go into their room and offer immediate support as they were finding it hard to communicate how they were feeling and needed support from staff

My Shared Pathway (involving service users of secure mental health services which started as Department of Health-led initiative https://www.england.nhs.uk/get-involved/why/public/my-shared-pathway) was used for each patient which centred around the patient, family and or carers. This included mental health recovery, managing problem behaviours, life skills current and to be addressed, relationships and future plans including discharge.

Our findings

Staff regularly reviewed and updated care plans when patients' needs changed, we saw this clearly demonstrated in each of the flies we reviewed, with evidence of patient involvement in this and at the Multi-Disciplinary Team meeting (MDT)

All patients had a PBS (Positive Behaviour Support) plan which highlighted areas of treatment and management, these were reviewed regularly with the patient, and those important in their lives, if consent had been agreed.

Patients told us they didn't always get their one-to-one sessions weekly, but it was due to staff being on holiday or if they were unwell or short of staff, they did say it was rearranged for another day. We saw evidence of the timetables both individual and group, and spoke with the Occupational Therapist who shared her planned daily and weekly, individual and group sessions.

Patients told us they had support from the psychologist who helped them with their treatment plans. This could be one to one or group work, for example the Sex Offenders Treatment Programme (SOTP), these were all assessed at a skills level and person centred. All had outcome goals, which had regular reviews.

Other psychology based treatment programmes included Eye Movement and Desensitisation and Processing (EMDR) with specific targets based on efficacy in people with Learning Disabilities, Dialectal Behavioural Therapy (DBT), a Talking Therapy, Cognitive Behavioural Therapy (CBT), and trauma based recovery treatment. The psychology team had adapted these programmes to meet individual needs and pathways.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service and supported patients to engage in therapy that enhanced their knowledge of their needs, future plans and or crime related therapy.

Staff used a "what does my sentence mean?" document, which was written and in easy read format. It explains sections, timescales, treatment available, appeals for sentences and sections, tribunals and discharge.

An audit of the therapy programme detailed their best practice, lessons learned and recommendations, all resulting in a more easily accessible treatment programme, sharing the information throughout the service, and ensuring all patients were offered and given a programme of activities for the ward. We saw evidence of this on the ward notice boards, we also saw patients referring to it for their daily activity plans.

Staff delivered care within the National Institute for Health and Care Excellence guidelines for best care.

Patients' physical needs were assessed on admission and were updated regularly using National Early Warning Score (NEWS) recording sheets.

Our findings

Staff supported and encouraged the patients to live healthier lives, this was part of their daily living skill education. There was a healthy eating group, which was optional to attend, opportunities to voice their concerns about the food they were supplied, options other than the food sent from the kitchen and a choice to buy their own snacks if they preferred, all of which were a regular topic of conversation at the daily and weekly meetings on the ward.

Healthy living groups were available, including the healthy walking group and healthy eating group and we saw evidence of these taking place.

Patients' files contained records of dental visits, optician visits, and hospital check-up appointments. Chiropodists appointments were available if required.

Patients we spoke to said the food was not nice, and that they had raised this several times to management. Management was aware of this and had sought a different catering contract supplier. This new contract is due to start in October 2023.

Managers told us that they were working towards accreditation with the National Autistic Society to assure themselves of the quality of the support and care they provided to autistic people. People from the service were involved in a working group for this.

The service told us about several initiatives and innovative practice. This included ongoing restorative practice work, and an anti-racism working group with various projects including development of the Active Allyship Group and programme. The latter, which was agreed by people using the service, involved specific care plans and a report to the police for individuals who displayed racist behaviour. This was to address the racial abuse received by staff working with people on the wards. In addition, staff were involved in various research topics such as sex offender treatment for men with a learning disability, the use of Eye Movement Desensitisation and Reprocessing (EDMR) on people with a learning disability, staff experiences of racism at work and recently published collective research on working with people with autism in the Criminal Justice System. Staff had already delivered in house Autism training with support from a clinical psychologist and a person who used the service. This received very good feedback and the service sent us a copy of the outcomes. They are hoping to continue delivering this training. Staff had already delivered in house Autism training with support from a clinical psychologist and a person who uses the service. This received very good feedback and the service sent us a copy of the outcomes. They are hoping to continue delivering this training.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. Patients we spoke to said they received good care and were happy with it. As the service provided regular supervision and appraisals, staff were more aware of good practice and had knowledge of the patients they were caring for.

Staff we spoke to said they were happy in their work and felt very well supported by managers and peers. This included the bank staff used.

Our findings

Managers assured us that they attempted to have at least one Learning Disability nurse on duty for each shift alongside Mental Health Nurses, but it was not always possible for this to happen if people were on leave or on sick leave. There were Team leaders on all shifts who had experience and some training in Learning Disabilities and Autism but were not qualified nurses. Since inspection we were told that most support staff on the ward had years of experience working with people with a learning disability and autistic people, both within the Trust and at other services.

However, in July 2022, the Health and Care Act 2022 set out a mandatory training requirement for learning disability and autism for the health and social care workforce. The government

recommended the Oliver McGowan mandatory training on Learning Disabilities and Autism which became available in November 2022 and provided two tiers of training dependent on what was appropriate for staff's roles. During inspection some staff told us that they had received correspondence around mandatory training for people with a learning disability and autistic people although they were not clear on what this was. Due to the nature of this service, the mandatory training was being delivered in two parts. The first part, available and mandatory for all staff from the beginning of April 2023, was an e-learning package. The second part, involving face to face training, was to be rolled out in Autumn once they confirmed a provider for this training. The Trust have told us that these courses need to be completed within six months of one another and that they were working to procure this face-to-face training provision by October 2023. Currently, 75.76% of staff at Tarentfort Centre have completed the mandatory e-learning.

The impact of some staff not having adequate knowledge and training meant that we could not be assured that the provider was ensuring that all staff had the right skills and understanding to provide the right care to people with a learning disability and autistic people

All staff received a full induction prior to starting on the ward, and to the ward where they shadowed regular staff for two weeks.

Appraisals were at 100% completion and supervision was at 79%.

Clinical supervision was offered monthly to all clinical staff.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers did not ensure staff received specialist training for their role. The essential training list received at the time of inspection did not include any specific training inputs on working with people with a learning disability and autistic people. The service provided evidence of specialist induction training for the directorate which showed three days of skill training and inputs and included sessions on communication, working with people with learning disabilities and working with autistic people which were run twice a year. We saw evidence that this programme was advertised for all existing staff to attend, although this was not mandatory and the Trust have told us that 41 staff members across the low secure services have attended this over the last two years. The service also provided a proposed five day timetable due to start later this year with the same agenda, as well additional inputs including closed cultures. A closed culture is a poor culture in a health or care service that increases the risk of harm. The Trust have since told us that it was hoped that this training will become mandatory training for staff. Although staff we spoke to said they had the opportunity to apply for relevant external training.

Our findings

Managers implemented performance management for people whose performance was not at an acceptable level and supported staff to increase confidence and knowledge in their roles.

Multi-disciplinary and inter-agency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff from different disciplines worked collectively as a team to ensure patients received support and care with all aspects of their daily living.

Patients said there were a lot of the team present most of the time and that they had access to them. This included nurses, doctors, social workers /care coordinators, speech and language therapists (SALT).

Staff we spoke to said there were positive working relationships between the disciplines and felt supported by each other. The staff told us that there was good communication with other services outside of the ward environment who were community based and helped with the planning for discharge and family contact. There is a family liaison officer, Community Learning Disability Teams with Forensic input, Outreach service, Multi Public Protection Arrangements (MAPPA) police Violent and Sexual Offender Register (VISOR) teams involved in organising the discharge pathway for people.

There was a fortnightly system wide discharge planning meeting called 'Homes not Hospitals' where peoples discharge plans were discussed. We attended one of these meetings which was a valuable tool in planning discharge and referrals.

The Multi-Disciplinary Team (MDT) were kept informed and up to date with any significant changes to patients' care plans, risk assessments and activities of daily living, any physical or mental health changes and incidents. These were also discussed collaboratively in the daily handover and Multi-Disciplinary Team (MDT) meetings.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff told us they were aware of the Mental Health Act and Code of practice, and its principles and their roles within this. They were able to describe these when spoken with.

Staff told us that the patients were read their rights and their understanding of them was observed and recorded. If someone found it difficult to understand, staff would read it to them in a way they would understand, verbally with visual prompts or with easy read documents which had been developed or written.

Staff displayed information about informal patients' rights on both entrances and exits.

Patients informed us that they had their rights read and explained to them every month, which was evidenced in their care notes. These were signed and dated.

Our findings

There was easy access to Independent Advocates for the patients, and they also had access to an Independent Mental Health Advocate (IMHA) who the patients knew of and knew how to contact. The Independent Mental Health Advocate also attended the service on a weekly basis. Staff displayed information about the Advocacy services available to patients on the notice boards on the ward.

We saw evidence of consent to treatment in the medicines folders and the care notes. This was reviewed regularly by the psychiatrist responsible for care.

There was clear evidence that the staff worked closely with the patients in identifying the best treatment for them during their stay, this was recorded in their care notes.

Staff training for the Mental Health Act was 100% for both clinical and non-clinical staff.

Staff respected the rights of people with capacity to decline medicines and that they had that option.

Section 17 leave (permission to leave the hospital) was agreed by the Responsible Clinician (RO) and or the Ministry of Justice (MOJ)

Staff ensured Section 17 leave was facilitated where and when planned and if unforeseen circumstances arose, the leave would be discussed and planned there and then, patients told us this did happen.

All leave was facilitated following a daily risk assessment and was recorded according to policy and legal paperwork requirements. Patients who had leave were aware of the conditions attached to this.

All detention and leave papers were stored safely on the electronic system and paper files and staff were able to easily access them.

Regular audits were conducted to ensure all paperwork was correctly adhered to.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received up to date training in the Mental Capacity Act (MCA). Their training compliance was 96.15%, which was above the trust target of 90%.

Staff we spoke to had a good knowledge and understanding of the five principles of the MCA and were able to relay this information to us.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff supported and empowered patients and gave them every opportunity to make decisions before they were deemed as not having capacity. It was an inclusive process.

Our findings

If staff felt patients did not have capacity to make decisions themselves, then decisions would be made in the best interest of the patient. In doing this they considered their culture, wishes, feelings, thoughts, and any relevant history.

Patients told us that their families were involved in their care if consent was given.

Carers, family members or relatives we spoke to also said they were involved in planning of care and decision making.

Managers told us that they monitor the application of the Mental Capacity Act using regular audits, any issues arising would be addressed and lessons learned from this.

We saw no evidence of Deprivation of Liberty Safeguards having been applied for in the last 12 months. These would only ever be applied for by staff if necessary, at which point they would be closely monitored.

Is the service caring?

Inspected but not rated

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment, or condition.

Patients told us that they were treated with kindness and respect, but sometimes staff would not listen to them, they said this was mostly the bank staff and that the regular staff were really understanding. They also told us that sometimes it took a long time to get things done for example repairs to their rooms, but that they were kept informed of the progress.

Patients told us staff respected their dignity. Patients told us that staff knocked on doors before entering and they took notice of what the message was on their traffic light boards on their doors.

Patients told us that the staff supported them in the more difficult times and if they were unsure or worried about something. They told us staff would take them to a quiet area of the ward for personal discussions.

Patients said they were given opportunities to try new activities and that the staff were really good at supporting this. They said therapists were involved in exploring new activities, hobbies, and skills.

Patients we spoke to said they had learned a lot of new skills since being on the ward, for example, managing money, shopping, managing behaviour and community access.

Staff we spoke to felt they had a good understanding of what they could raise concerns about and felt confident in doing so to the manager. They understood they could raise issues around discrimination, verbal, and physical abusive behaviour towards patients and said they were listened to.

Staff were all aware of the policy on confidentiality.

Our findings

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Staff introduced patients to the ward, their peers, and staff on admission. We saw evidence of an introduction to the ward information pack, which staff would support patients in reading if needed.

Patients told us that they were involved with their care planning and risk assessments and that they could have a copy of these if they wanted to or decline this and ask for it at a later time.

Patients said they had access to care plans and risk assessments in written, or easy read/pictorial formats.

Patients told us they attended regular ward rounds to discuss their current and future plans, they felt they had a good opportunity to be able to ask questions and make requests for leave and or visits, medication, and therapies.

Patients told us they attended their Care Programme Approach (CPA) meetings, these were clearly documented in their care notes and what involvement they had.

There was good evidence of treatment programmes identified and participated in. There were good records of progress within the treatment programmes and consultation with the patients.

Where communication difficulties were identified the preferred and adapted method of communication was used to inform the patient, the use of easy read documents, talking mats, pictures and verbal communication was recorded for each patient's preference.

Weekly community meetings afforded patients opportunities to feedback any complaints, compliments or concerns from. All meetings were documented and minutes were available to the patients if requested.

Where decisions around the service provision were deemed appropriate, patients were involved in the decision making, for example, they were asked for their thoughts on the garden, on the traffic light on doors communication system, additional activities, or therapeutic programmes.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Carers told us they felt very well informed and were encouraged to be involved with their family member's care.

They were also involved in service feedback which was sent to them by the service.

A family liaison officer was involved with the service who kept families and external service providers updated on what was happening in the service and future plans.

Carers told us that they could contact the ward at any given time should they want or need to.

Our findings

Is the service responsive?

Inspected but not rated

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Managers told us there was currently one person experiencing delayed discharge, and this was due to being able to identify and secure an appropriate placement for the patient which was closer to home and met their needs.

The service worked closely with community-based care coordinators, social workers, commissioners, and specialist teams, and we saw evidence of the joint work in the admission, discharge and planning meetings in the patients' files.

Bed management

Bed occupancy was not above 85%.

The service had no/low out-of-area placements.

Managers and staff worked to make sure they did not discharge patients before they were ready.

Patients were neither admitted or discharged early in the morning or late at night. We saw dates and times of admissions and discharges were clearly documented in patients care notes.

Managers informed us that there was always a bed available on return, for those patients who had been on leave.

Discharge and transfers of care

Managers regularly reviewed length of stay and audits showed that patients were not staying any longer than they needed to.

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

We saw that one patient had been moved from one side of the ward to the other in order to reduce risk and protect the patient's safety. Since merging the two wards into one, it has made this provision more easily manageable and accessible, without disruption. There was a clear protocol as to when and why this should be implemented and agreed by the multi-disciplinary team and followed the national standards for transfer.

Patients told us that they were supported well by staff if they needed to transfer or move temporarily.

Our findings

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Patients could make hot drinks and snacks at any time, although most patients gave negative feedback about the food.

During the inspection some of the patients invited us to look at their rooms, these were all individual en-suite bedrooms, and all fitted with anti-ligature equipment, for example, curtains and shower rails were non weight bearing, door handles and taps were anti ligature.

Each room was personalised if the patient wanted to do so, we saw they had posters, pictures, soft toys and football team memorabilia. The patients told us this made it more comfortable and a place they could relax in.

The furniture was modern, comfortable, and fit for purpose.

There were lockers available for each patient, whereby they could store their belongings and were aware of how to access them.

There was a ward phone which the patients had access to and knew how to access, they were able to have privacy during phone calls.

There were rooms available where the patients could meet with visitors, we did see evidence of all rooms and visits having a risk assessment for the individual patients.

Patients told us they could and did purchase their own snacks and drinks.

Hot drinks were available for the patients to make although all rooms were risk assessed as to the safety of the individuals.

70% of the patients we spoke to said the food was awful and they had raised this many times at their community meetings. They were frustrated at the quality and choice. Managers were aware of this issue and were in the process of securing a new catering provider for the ward to improve food quality and that doesn't take staff away from the environment to prepare meals.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff supported patients with family contact by phone, visits and video calls. Carers we spoke to said that it was good to have the video calling resource, especially as the train strikes and Covid had an impact on their visits at times.

Patients told us that they were supported to have community access and that by planning their leave in advance they were able to choose a facility they wanted to visit, for example they enjoyed going bowling, to the cinema, shopping or walking amongst other activities offered. There was a good freedom of choice for the patients.

Person centred support was given by staff who encouraged the patients engage in their self-care, independence skills and choices, and supported them when they asked for support.

Our findings

The activity programme was available to all patients and there was a copy on the notice board, available to all patients. The OT was involved in the activity planning and the participation of treatment programmes, with the group and on an individual basis. Patient participation was good and they were listened to by staff supporting them.

The OT also looked into community-based activities and potential work and college placements in the wider and local communities.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication difficulties or other specific needs. There were some patients on the ward who were supported with individualised communication tools. We saw a lot of evidence of pictures and words associated, diaries for individual patients, posters and photographs.

There was a traffic light system used for each patient who wanted to, whereby picture and word cards were available to all individuals. These were kept in their rooms and they would use these to demonstrate how they were feeling and if they needed support but were unable to vocalise this. Green gave an indication that they were feeling fine and did not need any intervention currently. Amber indicated to staff that the person needed them to knock on their door and check if they needed some help or support. Red indicated that the person needed someone to go into their room and offer immediate support, as they were finding it hard to communicate how they were feeling. We saw staff observing these details and responding if someone needed support.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The service had information leaflets available in languages spoken by the patients and local community. These were available in easy read format as well. Although, the notice boards based within the reception area to the wards were not always in easy read format or accessible for people. These boards had a considerable amount of information displayed, most of which was not easy read.

The service had information leaflets available in languages spoken by the patients and local community. These were available in easy read format as well.

There was an interpreter available should anyone need one and staff were able to demonstrate the process of how to access this.

Staff supported the patients with their access to advocacy, cultural and spiritual needs. We saw evidence of this in the care notes as to individuals' preferences.

People were supported with their sexual/ religious/ ethnic/ gender identity without feeling discriminated against. The service met the needs of all people using the service, including those with needs related to their protected characteristics. People were referred to by their preferred name and the information around preferences was in people's communication profiles. The service also had a number of resources to meet spiritual, cultural and gender needs. These included a variety of religious and non-religious representatives with contact details available, contact details for people in the form of support groups or individual counselling.

Our findings

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

People and those important to them could raise concerns and complaints easily, and staff supported them to do so. Although there was no information clearly displayed on the ward on how to make a complaint, people told us that they felt comfortable and knew how to make complaints. Most people told us that they would approach the ward manager in the first instance and were confident that their issues would be resolved.

Patients and carers we spoke to were able to explain the complaints process and acknowledged support was available to them both if they needed it from staff.

One carer said she had to make a complaint, but this was resolved immediately and she was kept informed throughout the whole process.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. In the last 4 months there had been 6 compliments, 1 PALS concern and 2 complaints, all of which had been addressed and resolved.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. This was undertaken weekly at the multi-disciplinary team meeting and discussed at the daily handover with staff.

Patients had the opportunity to raise concerns and or complaints and compliments at any time, but the weekly community meeting was deemed a good place to have discussions around these. The patients we spoke to said they were happy doing this and felt well supported by staff to do so.

The service used compliments to learn, celebrate success and improve the quality of care. We saw thank you cards and letters of appreciation from carers, family members and patients current and past, on display, celebrating their work.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Our findings

We saw that there was a very experienced and knowledgeable senior leadership team. They had a clear understanding of patient and staff needs.

They put the needs of the people they cared for first and the patients needs and wishes were at the centre of all they did.

Leaders worked hard to instil a culture of care in which staff truly valued and promoted people's individuality, protected their rights, and enabled them to develop and flourish. All staff we spoke with said they felt valued and supported in their role. Staff understood their role in enabling people to move on successfully back into the community and spoke passionately about working with the people using the service.

Managers were visible on the ward and patients and staff were aware of who they were. We saw some patients spending time with the managers and looked comfortable and well supported in doing so.

The management team put equal value on their multi-disciplinary team members, families, advocacy, and people using the service.

Leaders and senior staff were aware of the culture in the service and as part of this spent time with staff/ people and family discussing behaviours, management and support, and values.

Managers and people on the ward told us about the racial abuse received by staff working with patients on the wards. The service is involved in an anti-racism working group to improve the racism experienced by staff within the service.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff were able to discuss the values and vision of the service and how this applied to their work.

These included the core values of openness, accountability, excellence, innovation and working together as a team.

These were displayed on the ward so that people using the service and their relatives knew what behaviours and values they could expect to see from staff.

The provider had a clear vision for the direction of the service that demonstrated ambition and desire for people to achieve the best outcomes possible.

We saw that staff wanted to do the best possible job they could in delivering care.

Staff told us that patients were a priority and at the forefront of everything they did. People told us that they felt that staff cared for them and their wellbeing, and their families.

Managers set a culture that valued reflection, learning and improvement. They were receptive to challenge and welcomed fresh perspectives. All staff we spoke with told us the ward was approachable and welcomed feedback from staff on how to improve things. The service held "meet the manager" sessions and had a workforce "you said, we did" process. Any items from these were fed into the clinical governance agenda for wider discussion.

Our findings

Outcomes were fed back to the patients.

Culture

Staff felt respected, supported, and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All staff told us they knew how to and felt confident in raising concerns. They felt that the manager took this seriously and would work with individual staff and group education, in problem solving and resolution of these issues.

Staff knew about the Freedom to Speak Up and whistleblowing policies.

Information was displayed about the speak up process on the ward and staff received essential training on this.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Governance processes operated effectively and helped to hold staff to account, kept people safe, protected their rights and provided good quality care and support. Staff discussed risks relating to individuals, incidents, and staffing levels for the day in the daily morning meeting. Any issues were escalated to multidisciplinary meetings held daily.

There were weekly service level governance meetings and monthly directorate, quality and clinical governance meetings. We saw that the agenda included discussions around: serious incidents including lessons learnt, safeguarding, risk registers, reducing restrictive practice, quality improvement projects, care records, audits, complaints and compliments, and feedback from people using the service, carers, and advocates. The weekly service level governance meetings discussed specific areas of the wider clinical governance agenda each week and this fed into the monthly directorate meeting and the wider trust wide governance meetings. Information from all of these governance levels was also able to be filtered down to ward level team meetings. This meant that relevant information was being shared across the right channels.

Staff used recognised audit and improvement tools to good effect, which resulted in people achieving good outcomes. Staff did clinical audits, bench-marking, and quality improvement work to understand and improve the quality and effectiveness of care. The service had audit systems in place to assess and monitor the standards of care and action was taken where shortfalls were identified. The service had a governance lead who monitored and reviewed data relating to the service to identify any concerns or themes. The service carried out regular audits including those of the environment, care, and medicines, as well as thematic clinical audits on different areas of the service including therapeutic programmes for example. The purpose, outcomes and recommendations of these were put into clear one-page documents, which were disseminated to staff for learning and placed onto the wards.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff had access to patient's individual risk assessments and care plans and showed they had read these.

Staff were able to demonstrate what the risks were and what plans were in place to prevent and reduce these.

Our findings

The service had an overall risk register which staff also had access to. This covered high risk areas of the ward and described mitigations to manage the risks. We also saw evidence of a clear referral and admission process, with inclusion and exclusion criteria which supported leaders to manage inappropriate referrals and ensure that they only admitted people they could support and care for safely.

Staff were committed to reviewing people's care and support continually to ensure it remained appropriate as people's needs and wishes changed. People told us, and we saw, that care plans were regularly reviewed. The multidisciplinary team reviewed each person's risk at the daily morning meeting and at ward rounds. Patients told us that they were encouraged to attend these meetings and felt well supported in doing so.

Staff were able to explain their role in respect of individual patients without having to refer to individual files. They gave good quality support consistently. Throughout our inspection we observed that staff supported patients well.

Staff acted in line with best practice, policies, and procedures. They understood the importance of quality assurance in maintaining good standards. There was an appropriate clinical governance. structure in place to ensure information and risk was escalated and managed in a timely manner.

Leaders confirmed that organisational policies and procedures from the wider trust were applied to the operational running of the ward and that updates to these were shared with staff.

The policies and procedures that we received from the service were clear and regularly reviewed.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. Clinical governance meetings demonstrated that managers had reviewed data and bench marked these across the wider care group. The staff routinely completed Health of the Nation Outcome Scales (HONOS), which is a recognised rating scale to assess and record outcomes for people.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

People were the most important aspect of everything the staff and management team. We were informed by all staff we spoke to that this was their main priority. Carers also stated that they knew that their family member was the most important thing for staff on the ward.

Feedback was captured from people regularly at the weekly ward community meetings and through ward rounds. We saw evidence of community meeting minutes where people fed back suggestions and ideas. All people were invited to the community meetings. People told us that they also had surveys regularly to feedback.

Our findings

The service held formal listening events for family and friends to share their views and discuss issues with staff. The service used their comments to improve the service. Staff actively sought the views of carers via the family engagement and liaison lead who held carers forums to enable carers to communicate feedback informally. They also provided them with the NHS Friends and Family Test (FFT) which is part of the Patient Reported Experience Measure (PREM) and enable carers and relatives the opportunity to engage. Carers we spoke to said this was an invaluable forum.

Senior leaders told us that they had representative roles for those using the service. This involved people receiving training for this role. Quarterly, these representatives and carer representatives joined the clinical governance meetings. The service provided easy read minutes and agendas for these meetings.

The service also sought feedback from staff which included a yearly staff survey, team meetings and more local supervision processes.

Managers engaged with other local health and social care providers and participated in the work of the local transforming care partnership. Managers ensured that each person had regular CPA and C(E)TR meetings. They participated in these and shared information about the person to inform these. Staff worked with providers where people had previously lived or were moving to which helped ensure the best outcome for the person.

Learning, continuous improvement and innovation

The service's quality and governance structures, which included recommendations from audits, complaints and learning from incidents ensured that improvements were made as a result. The themes or particular aspects of learning were also taken to directorate meetings and to the Trust wide Patient Experience Group to highlight the issues and what action had been taken to ensure accountability.

Leaders had a clear vision for the direction of the service which demonstrated ambition and desire for people to achieve the best outcomes possible. The service were using the standards under the National Autistic Society Accreditation (NASA) to guide their vision in improving the service to enable better outcomes for people. Some leaders and staff told us about initial plans to make changes to the environment. The Trust were carrying out sensory environment audits to see what areas of improvement were needed, as well as identifying existing good practice. People using the service were invited to these audits and on the working groups where these plans were being made, so that they were involved in providing input and feedback in the changes to the current environment. The Trust also told us that they had plans to have sensory leads on the wards.

Psychology staff were also engaged in a number of research projects linked in with local universities. The service was a research pilot site for sex offender treatment for men with a learning disability and the use of Eye Movement Desensitisation and Reprocessing (EMDR). We also saw that the service was accredited through the Royal College of Psychiatrists for the Accreditation for Inpatient Mental Health Services (AIMS) for Rehabilitation. This accreditation recognises high standards of organisation and care and this included a peer review of the service. Leaders used this to help make improvements to the quality of the service of psychotherapy on people with a learning disability.

Staff were also carrying out research on staff experiences of racism at work. Several staff working for the service contributed to a recently published collective of research on working with people with autism in the Criminal Justice System.

Our findings

Some staff told us that due the current financial climate, the trust had put in place a wellbeing hub to assist with wellness, staff retention, and to provide advice and guidance to help them financially, such as foodbanks. The service also held regular team days for the staff on the ward.

Our findings

Outstanding practice

We found the following outstanding practice:

The treatment programmes devised by Psychology, with MDT input for implementation, were excellent. They were effective in their implementation and had positive results from this. They had also been chosen as a centre for therapy research including Eye movement desensitisation and reprocessing (EMDR) and Trauma Based management in Learning Disabilities. They had also been chosen to undertake National research for the Sex Offenders Treatment Programme (SOTP) based on their achievements to date. The service also worked closely with people using the service to design and deliver training. The service used restorative practice to help manage conflict and resolve incidents on the ward. Restorative practice brings those harmed by conflict and those responsible for the harm into communication, enabling everyone affected by a particular incident to play a part in repairing the harm and finding a positive way forward. They have been accredited for their work with this. The service had an anti-racism working group with various projects including development of the Active Allyship Group and programme. The latter, which was agreed by people using the service, involved specific care plans, and a report to the police for individuals who displayed racist behaviour. This was to address the racial abuse received by staff working with people on the wards. Staff were also carrying out research on staff experiences of racism at work. Staff recently published collective research on working with people with autism in the Criminal Justice System. This was something staff were proud of and reinforced what they were doing within the service themselves

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

The service must ensure they admit people who are appropriate to the Forensic Learning Disability Service which can enable therapy to be implemented and risk to reduce in respect of increasing sexualised behaviour. (Regulation 12: Safe care and treatment)

The service must ensure that the seclusion room door is made safe for people who need to use the area. (Regulation 12: Safe care and treatment)

The service must ensure that the ligature risk assessment is updated and includes the seclusion room door. (Regulation 12: Safe care and treatment)

The service must ensure that all staff working with people with a learning disability and autistic people are competent and equipped with the essential knowledge and skills to understand and work with the specific needs of people using the service. (Regulation 18: Staffing)

The service must ensure that a new catering provider is sought in line with the issues raised by the people who live at the unit. (Regulation 14: Meeting nutritional and hydration needs)

Our findings

Action the service SHOULD take to improve:

The service should consider making improvements to the efficiency of finding necessary information within peoples care records.

The service should consider making improvements to the notice boards within the reception area, to make these more accessible for people using the service.

The service should ensure fire risk assessments are in place for people prescribed paraffin-based skin products.

Our inspection team

The team that inspected this core service comprised of four CQC inspectors (two mental health inspectors and two medicines inspectors) and one specialist advisor. One of the inspectors was a registered learning disability nurse and the specialist advisor had experience working with people with learning disability and autistic people. These visits were carried out across three days over two weeks. A CQC Mental Health Act Reviewer (MHAR) also carried out a focused mental health act review of Tarentfort Centre.

During this inspection we considered aspects of the following key questions:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the inspection visit, we reviewed information that we held about the hospital.

We also spoke to three carers prior to the inspection visit.

During the inspection visit, the inspection team:

Undertook a tour of the unit to look at the quality of the environment.

Spoke to 10 people who use the service.

Spoke to 13 staff members.

Carried out direct observations of care using the Short Observational Framework for inspection (SOFi). SOFi is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe this themselves because of cognitive or other problems. It enables inspectors to observe people's care or treatment looking particularly at staff interactions.

Attended a Multi-Disciplinary Team meeting (MDT)

Attended the referrals meeting, this included engagement from outside agencies.

Looked at 10 care records.

Looked at all medication cards.

Reviewed policies and procedures.

Looked at audits which showed the provider was evaluating and making necessary changes in all aspects of the service.

Our inspection team

Observed activities.

Attended the daily risk meeting.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing