Coventry and Warwickshire Partnership NHS Trust

Forensic inpatient or secure wards

Inspection report

Trust Headquarters, Wayside House
Wilsons Lane
Coventry
CV6 6NY
Tel: 02476362100
www.covwarkpt.nhs.uk

Date of inspection visit: 17, 18 and 23 May 2022
Date of publication: 16/09/2022

Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive to people's needs?	**Inadequate**
Are services well-led?	**Inadequate**

Our findings

Forensic inpatient or secure wards

Inadequate ⬤ ↓↓

The forensic inpatient wards are four wards based at the Brooklands Hospital site. Brooklands is a specialised hospital site which provides inpatient care and treatment to adults and children with a learning disability or autism. The hospital is part of the learning disability and autism services delivered by Coventry and Warwickshire Partnership NHS Trust. Four forensic inpatient wards are based at the Brooklands Hospital site. The low secure ward environments have been updated to ensure that it complies with low secure standards but the medium secure ward had not been updated for many years. The trust was working with commissioners to modernise all the wards on the Brooklands site as part of an estate's management plan, but further work is required to ensure all buildings meet the needs of people who use the services on site.

The forensic inpatient wards comprise of the Janet Shaw Clinic, a medium secure ward for adult men, Eden ward, a low secure ward for adult women, Malvern ward, a low secure ward for adult men, and Rainbow ward, a low secure ward consisting of three individual apartments for men with a diagnosis of autism.

Our rating of this service went down. We rated it inadequate because:

- People living in the service were not always kept safe due to staffing levels across the wards. Incidents had occurred at times when observations of people were lowered due to staffing shortages.
- People were not safeguarded from bullying and intimidation from other people on the Janet Shaw Clinic. This did not meet the standards of the CQC guidance, Right Support, Right Care, Right Culture, which is statutory guidance in accordance with Section 23 of the Health and Social Act 2008. In particular, the guidance specifies that the ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.
- People who used the Janet Shaw Clinic were living in an environment that was poor and did not meet their needs. We found environmental concerns which meant that some areas were not clean or well maintained. There were dirty toilets and floors, a bedroom corridor had missing plaster from walls and flooring was either split or patches were missing. In addition, door hinges had a build-up of dirt and communal furniture was ripped or cracked.
- The service did not comply with infection prevent control standards. Although staff had undertaken audits of cleaning, these had not identified the issues found on inspection and did not appear to be effective. Cleaning of ward areas was not effective and often did not include people's bedrooms.
- People were sometimes subjected to overly restrictive interventions. There was evidence of some overly restrictive interventions. People were told they could not access section 17 leave if they did not attend to personal hygiene.
- The service did not comply with best practice standards for people in seclusion or long-term segregation. We found that seclusion and long- term segregation reviews did not always take place in line with the Mental Health Act Code of Practice guidance.
- Staff did not always have easy access to clinical information. The quality of the internet connection was poor across the site and this impacted staff's ability to access care records, safe staffing data or health rotas.
- People were not meaningfully occupied during the day or evening.

Our findings

- Senior leaders did not have effective oversight and did not monitor and mitigate effectively against risks relating to the health, safety and welfare of service users.
- There were not sufficient staff within the occupational therapy team to meet clinical need and complete specific assessments such as sensory assessments in a timely manner.

However, we found that:

- Care plans, positive behavioural support plans and risk assessments were detailed, individualised, and met people's needs. However, this formed only part of the person's care pathway and its effectiveness was impacted by a lack of activities and opportunities for community education and work.
- There was comprehensive input and involvement from the psychology team and people had access to a range of group and individual treatment programmes and psychological work.
- There was a full range of specialists present at multidisciplinary teams.
- People spoke positively about regular staff on the wards. They said they worked hard, were caring and supportive.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Wards were not always safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff did not always regularly update environmental risk assessments of all ward areas. On the Janet Shaw Clinic (a male medium secure ward for men), staff were required to complete a daily environmental checklist. During May 2022 we saw that 17 out of 23 checklists were not completed or only partially completed.

The ward was trialling a system for the environmental checklist to be completed using a tablet (a wireless portable computer with a touch screen). Staff had provided senior leaders with feedback that this took two hours to complete but it was not clear what action had been taken in response to this.

Staff could observe people who use the service in all parts of the wards and there were mirrors in place to mitigate any blind spots. However, in corridors on wards, we identified a number of door frames where a person may not be visible.

The ward complied with national guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep peoples safe. Staff had easy access to alarms and people had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Our findings

Some ward areas were dirty and poorly maintained. Other areas were poorly furnished and not fit for purpose. On Janet Shaw Clinic five bedrooms were in very poor condition, with dirty toilets and floors. A bedroom corridor had missing plaster from walls and flooring was either split or patches were missing. Most door hinges had a build-up of dirt and communal furniture was ripped or cracked. We also found that floors had dust and dirt at the edges. Managers told us about plans to replace the current wards with purpose-built units but at the time of the inspection there were no clear timescales for the completion of this work.

We spoke with staff who told us they tried to support people to clean and maintain their bedrooms. We also had sight of meeting minutes which showed that staff reminded people to try and keep bedrooms clean and tidy and that support from staff was available if needed. On the Janet Shaw Clinic, meeting minutes documented that cleaners were reluctant to visit the ward and conduct cleaning duties due to people being verbally abusive to them. It was unclear what steps managers had taken to address this. We were concerned that these issues compromised infection prevention and control standards and did not create an environment that promoted recovery. Some people on Janet Shaw Clinic complained about the cleanliness of the environment. We found a strong odour in the corridor from a cracked pipe and one person said that the showers gave off a strong smell.

Staff kept cleaning records, but these were not always up-to-date and did not appear to be effective in ensuring the premises were clean. A cleaning audit conducted on the day of inspection found that the ward was 98.3% compliant 'of areas visited' and did not appear to identify the environmental concerns of the inspection team. It appeared that the cleaning audit did not always include a review of bedrooms and we were concerned that there was a lack of process in place to identify and address areas of concern. All wards had a sign on the entrance to say they had received five stars for cleanliness. The inspection team raised these concerns with staff during the inspection and the trust undertook a deep clean on Janet Shaw clinic. They re-audited the environment on 7 June 2022 and scored the ward at 88.9% which meant it had a three star rating. The trust also advised us they had instigated a deep clean across all wards within the service.

We found that four gym machines had no evidence of having been serviced and that three of the four machines had no sticker confirming that a portable appliance test (PAT) had been completed. However, the trust had documented evidence that the gym equipment was serviced in March 2022 and all electrical equipment had been PAT tested on 9 June 2022. People told us the gym was rarely used due to activity workers being in the staff numbers.

The bingo machine was also not PAT tested and we saw that this had been used on the afternoon of 23 May 2022 for a group session. We were therefore not assured that PAT testing, servicing of electronic equipment or the process for risk assessing equipment was effective and safe.

Seclusion room (if present)

The seclusion rooms allowed clear observation and two-way communication, and each had a toilet and a clock. However, the seclusion room on Janet Shaw Clinic had a broken doorframe, there was no light over the toilet area and the blind on the external facing window was not working. In addition, the bed was positioned in a way that made it difficult to enable staff to leave the room safely.

The seclusion room on Rainbow ward had a broken hatch despite staff having reported it. A cupboard to store fire extinguishers adjacent to the seclusion room had belongings stored of a person not on the ward. They had been in seclusion six months previously. Staff had raised this issue with the neighbouring ward, but the persons belongings had not been collected. The outside space to the seclusion area did not protect people's dignity as it was overlooked by two outside gardens on site and the road through the site.

Our findings

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs present. We saw that staff checked these regularly. The clinic rooms we reviewed were clean, tidy and well maintained. Staff cleaned clinic rooms on a daily basis and kept up to date records to confirm this had taken place.

Staff checked, maintained, and cleaned equipment. Staff recorded the date that equipment was checked and when the next check was required.

Safe staffing

The service had enough medical staff, who knew people however, there were not enough regular nursing staff to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep people safe. Trust safe staffing levels were often not met across the wards. We reviewed the staffing data for the previous six- month period and saw that all wards had a high number of shifts that were short staffed. Janet Shaw Clinic had the highest, with 301 unfilled shifts. Rainbow ward had the lowest, with 177 unfilled shifts. At the time of the inspection, the staffing data showed that there were shortages on multiple wards for both day and night shifts for the coming weekend.

Ongoing staffing issues meant that patient observation levels were not always met. Staff used a standardised form to document the shortages and record where patient observation levels needed to be temporarily lowered as a result. We saw that incidents often occurred on days when patient observation levels had been reduced. For example, on Eden ward there were three incidents that had occurred at a time when observation levels were lowered due to a shortage of staff. Staff informed us that staff from other wards had been requested to manage these incidents. Staff shortages continued to increase the risk of incidents and the likelihood of staff being unable to observe people and carry out physical interventions safely. This meant that not only were people not being kept safe, but they had reduced opportunites for positive engagement and activity.

On Janet Shaw Clinic people told us they were fearful about their own safety, and the safety of staff and said that some people bullied and intimidated others. They reported a lack of adherence to behavioural boundaries and restrictions. In addition, people described how incidents of bullying behaviour were not investigated and dealt with effectively. However, the trust informed us that feedback from IMHAs, complaints, concerns had not identified incidents involving bullying.

People cited a lack of rules on the ward which meant people's behaviour could continue without intervention. This did not meet the standards of the Right Support, Right Care, Right Culture statutory guidance. In particular, the guidance specifies that the ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

The service had high turnover rates. Rainbow ward had the highest turnover rate over the previous 12-month period at 25%, with Janet Shaw Clinic having a turnover rate of 19.5%. The service had a high number of vacancies. At the time of the inspection there was an average of 2.14 vacancies across the wards. This meant that the number of bank and agency nurses or nursing assistants remained high and that most shifts needed additional support from the NHS professionals bank.

Our findings

Managers told us they requested bank and agency staff who were familiar with the service wherever possible but there were often staff on shift who did not work on the ward regularly or did not know people on the ward. Nevertheless, managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. However, people told us that not all agency staff knew what their needs were.

Managers supported staff who needed time off for ill health. Levels of sickness were generally high, with Malvern ward and Eden ward having the highest average sickness rates of 20% and 12.5% respectively over the previous 12-month period. Managers described the challenges of Covid-19 on staffing and said the pandemic impacted sickness levels across the service but felt this was improving in recent months.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift, although they could not always adjust staffing levels according to the needs of people. People told us they did not always have regular one to one sessions with their named nurse, and said that staff were often too busy to spend time with them.

People said they sometimes had their escorted leave or activities cancelled when the service was short staffed. They described how the activities workers had been making up the substantive staff numbers. This meant that these specialist staff were unable to arrange group or individual activities.

Staff shared key information to keep people safe when handing over their care to others. We had sight of written handovers and found these to be detailed and of good quality.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There were no current vacancies within the medical team.

Managers could usually call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

There was a process in place for managers to monitor mandatory training and alert staff when they needed to update their training. The mandatory training programme was comprehensive and met the needs of people and staff. Staff mostly completed and kept up-to-date with their mandatory training, but the service did not meet its' overall target. Statutory and mandatory training compliance was 87% for the service overall, with Janet Shaw Clinic having the highest at 91% and Malvern ward the lowest at 78% against a trust target of 90%.

We saw that only 36% of staff had completed basic life support training and 69% had completed immediate life support training. Managers told us there was a resuscitation response process in place, which meant that when resuscitation was required, a registered nurse from each ward was alerted and attended the ward to respond.

Assessing and managing risk to people and staff

Staff mostly assessed and manage risks to people and themselves well. They mostly achieved the right balance between maintaining safety and providing the least restrictive environment possible to support peoples'

Our findings

recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of people's risk

Staff completed risk assessments for each person on admission, using recognised tools such as the HCR20 (V2). Risk assessments were reviewed regularly, including following incidents or changes in presentation.

Staff assessed peoples' risk of violence and aggression and implemented a plan to monitor and manage identified risks.

Management of people's risk

Staff knew about any risks to each person and acted to prevent or reduce risks. Staff gave updates on risk during handovers and also used a 'get to know each other folder' which provided summaries of people's positive behavioural support plans. These were shared with staff where necessary to ensure they had understood people's risks and triggers and enable them to identify and respond to changes in risk.

Staff followed procedures to minimise risks where they could not easily observe people. Staff followed trust policies and procedures when they needed to search people or their bedrooms to keep them safe from harm. However, bedrooms had many items within them that would make it difficult to search in a timely way and without causing disruption and distress to people.

Staff only searched people following section 17 leave if this was risk assessed as being necessary. Staff told us they did not conduct random searches. Staff also asked permission from people prior to searches and said they would escalate concerns with searching to the responsible clinician.

Use of restrictive interventions

Staff sometimes needed to use restrictive interventions on the wards in response to behavioural disturbances. Some staff told us that there was a focus on using de-escalation techniques to avoid the use of physical interventions and that this was included within the trusts' interventions training.

We reviewed data for the six-month period prior to the inspection and saw that Eden ward had the highest number of restraints with a total of 30, with Janet Shaw Clinic having 25, and Malvern 16. Rainbow ward had not needed to use restraint during that period. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep the people or others safe. The positive behavioural support plans we reviewed set out people's triggers and early warning signs and set out individual de-escalation techniques including what people found helpful to calm them down.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. However, there was evidence that staff did not always consider the least restrictive option. We reviewed meeting minutes from a therapeutic environment meeting on the Janet Shaw Clinic which documented that people were told they would not have section 17 leave if they did not attend to personal hygiene. We were concerned that this did not adhere to best practice guidance, in particular, the Mental Health Act Code of Practice which specifies that restrictions

should not be applied in order to punish, but only as a proportionate response to individually identified risks. We were concerned that this did not comply with the Right Support, Right Care, Right Culture model of care and did not maximise people's choice, control and independence. This meant that people had to comply with what they were told or their rights to leave and treatment would not take place.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Those staff we spoke with could explain the five principles of the Mental Capacity Act, and gave practical examples of how they applied the principles on the ward. Staff followed National Institute for Health and Care Excellence when using rapid tranquillisation.

We reviewed seclusion data for the 12-month period prior to the inspection and saw that Eden ward had the highest use of seclusion, with a total of 112 episodes. Janet Shaw Clinic and Malvern ward had 26 and 25 episodes of seclusion respectively. Rainbow ward had not used seclusion during that period.

When a person was placed in seclusion, staff kept clear records, but they did not always follow best practice guidelines. We found that prescribed seclusion reviews within the Mental Health Act Code of Practice did not always take place. For example, on Eden ward we found that staff had not completed two- hourly reviews of a person in seclusion on four occasions. Staff had documented that this was due to staffing issues. In addition, staff did not always follow best practice, if a person was put in long-term segregation. We reviewed a sample of long-term segregation records on Eden ward and saw that timescales for review as prescribed under the Code of Practice were not always met. We found that hourly reviews did not always take place, or staff did not record that these had taken place, particularly in the evenings or around the time of handovers. This meant that people may be held in seclusion or long-term segregation for longer than they needed and not subjected to the necessary safeguards under the Code of Practice, meaning they may be at risk of harm.

Safeguarding

Staff understood how to protect people from abuse and 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.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff were kept up-to-date with their safeguarding training. Level 1 training compliance for safeguarding adults was 97% and 94.5% for safeguarding children.

Staff could give clear examples of how to protect people from harassment and discrimination, including those with protected characteristics under the Equality Act. However, some people described how they felt bullied or intimidated by others and said that whilst regular staff were generally responsive, agency staff had not dealt with or managed this effectively.

The staff we spoke with understood how to contact internal and external safeguarding teams to obtain advice or discuss safeguarding concerns. Managers logged and monitored safeguarding referrals and those managers we spoke with were aware of any recent safeguarding referrals on the wards.

Staff followed clear procedures to keep children visiting the ward safe. Visits involving children took place outside the wards and these were risk assessed and supervised where necessary.

Our findings

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We reviewed a sample of safeguarding referrals and saw that these had been investigated, with the action taken, reason for referral, and involvement of external agencies clearly documented. Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff did not always have easy access to clinical information which meant it was not always easy for them to maintain high quality clinical records – whether paper-based or electronic.

People's notes were comprehensive and these comprised a mixture of paper and electronic records. However, staff could not always access the electronic records easily due to issues with the internet quality across the site.

Staff told us that the internet was not always accessible in meeting rooms or quiet rooms throughout the wards. They said that the nursing offices had the strongest internet connection but these offices also acted as reception areas which weren't private. This meant that staff couldn't always discuss or share confidential information. We observed poor internet connection throughout the inspection.

Staff told us the poor internet quality meant they couldn't always access care records, safe staffing data or health rotas, and also told us this impacted their ability to make use of video calls to liaise with external agencies.

When people transferred between services, there were no delays in staff accessing their records.

Records were stored securely. Documents were password protected and the trust allocated agency log in accounts to ensure non- permanent staff could access care records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each person's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff recorded and monitored fridge and room temperatures and the records we reviewed were in order.

Staff reviewed each person's medicines regularly and provided advice to people and carers about their medicines. People were provided with easy read advice about their medication. Staff regularly assessed and recorded each person's capacity to consent to treatment.

Staff completed medicines records accurately and kept them up-to-date. Staff stored and managed all medicines and prescribing documents safely. We saw that store cupboards and drugs trolleys were in order. Emergency drugs were present and in date and these were checked weekly by the pharmacy team. During the inspection we saw pharmacists checking and auditing medicines across the wards.

Staff followed national practice to check people had the correct medicines when they were admitted and when they moved between services. Staff learned from safety alerts and incidents to improve practice. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each person's medicines on their physical health according to National Institute of Clinical Excellence guidance. The records we reviewed contained evidence of ongoing physical health care and monitoring.

Our findings

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 safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave people honest information and suitable support.

Staff knew what incidents to report and how to report them. There was a system in place for staff to categorise each incident, provide a clear description, and seek approval from a manager prior to submission.

There was good oversight of incidents and these were reviewed by the matrons and senior managers. Staff told us that the risk management team produced regular incident reports which were circulated to managers and staff to enable themes and trends to be identified.

Staff raised concerns and reported incidents and near misses in line with trust policy. All the staff we spoke with were aware of how to report incidents and gave examples of them having done so.

Staff reported serious incidents clearly and in line with trust policy. There was a system in place to ensure staff were prompted to complete these where appropriate.

Staff understood the duty of candour. They were open and transparent, and gave people and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. There was a standardised form in place to document debriefs.

The service offered a trauma-focussed peer support system to staff following incidents. There were also staff within the trust who were trained to deliver this.

Managers investigated incidents thoroughly. People who use the service and their families were involved in these investigations where appropriate.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to people's care. There was a reflective practice forum, where lessons learned from incidents and what went wrong, were discussed.

There was evidence that changes had been made as a result of feedback. For example, staff explained how they had made changes to the use of electronic cigarettes due to a trend of self-harm incidents related to the batteries.

Is the service effective?

Requires Improvement 

Our findings

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all people who used the service on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected a persons 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 person either on admission or soon after.

People had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each person making sure it met their mental and physical health needs, and their needs for their learning disability and autism. We reviewed 10 care plans and saw that these were detailed and individualised to meet people's specific needs. There was evidence within care plans that staff had liaised with outside agencies where appropriate. Care plans showed evidence of involvement and input from family and carers.

Staff regularly reviewed and updated care plans when peoples' needs changed

Care plans were personalised, holistic and recovery-orientated. The care plans we reviewed set out individual care needs, and specified peoples' wishes and preferences where appropriate.

People also had positive behavioural support plans in place, which staff said were helpful in informing care and treatment decisions. Those we reviewed were focussed on risk reduction. They contained important information including communication needs, triggers and warning signs. People told us that regular staff understood their needs including some bank staff but staff less familiar with their needs meant they were not always followed.

Best practice in treatment and care

Staff provided a range of treatment and care for people based on national guidance and best practice. They ensured that people 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 people in the service. There was evidence of psychology input and people had access to a range of individual and group sessions. These included dialectal behavioural therapy, offender treatment programmes, mindfulness, and 'body and mind' sessions. People who were undertaking treatment programmes and therapy told us where they were in treatment, the benefits, and how this supported a move towards a less secure setting or discharge.

The psychology team delivered sessions to staff on a range of areas including understanding people's history or presentation, trauma, abuse or social issues. The team also facilitated case formulation with staff. There was evidence of ongoing support and guidance from the psychology team throughout people's treatment journeys. Staff delivered care in line with best practice and national guidance from National Institute of Clinical Excellence and other specialist advisors

Staff identified people's physical health needs and recorded them in their care plans. Staff made sure people had access to physical health care, including specialists as required.

Our findings

People were registered with the local GP to enable them to access physical health clinics directly. Staff used recognised rating scales to assess and record the severity of peoples' conditions and care and treatment outcomes.

People received a range of physical health checks and interventions including cervical smears, breast screening, and diabetic eye screenings. There was evidence that people also had regular eye tests and dental tests. Staff told us that the practice nurse and specialty doctors also supported people's physical health needs.

Staff met people's dietary needs and assessed those needing specialist care for nutrition and hydration. Referrals to the trust dietician were made on an individual basis where necessary. People could attend healthy food groups if they chose and staff encouraged those people who would benefit from these to attend.

The service monitored the food and drinks people received for salt, sugar and calories, and circulated guidance about portion control and calorie intake to staff and people. Staff described how they provided advice to people about healthy eating. However, two people told us there was too much bread on offer at mealtimes that impacted on their weight and well-being.

Staff took part in clinical audits, standard setting and quality improvement initiatives. Managers used results from audits to make improvements and could describe examples of how they done so. This included amending the procedures for checking drug charts and medication administration competencies following gaps identified from a clinical audit.

Skilled staff to deliver care

The ward teams had access to a full range of specialists. However, it did not have enough occupational therapists to meet people's needs on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision although these were not always received in a timely manner. We saw that there were some opportunities for staff to update and further develop their skills. Managers provided an induction programme for new staff.

There was only one occupational therapist working across the service. Many of the staff we spoke with raised this as an issue. They described a lack of occupational therapy presence at multidisciplinary team meetings and said that there were often delays in people receiving the appropriate occupational therapy intervention and support. For example, in one record we saw a person had been waiting for a sensory assessment for over two months. This had still not taken place at the time of the inspection and there was no current timescale for completion.

Managers gave each new member of staff an induction to the service before they started work. This included both permanent, agency and bank staff. We had sight of the wards' induction checklist and saw that staff had all received this. The induction was specific for secure services and included a detailed security induction.

Managers supported staff through appraisals of their work. Eden ward had the lowest compliance rate, with an average of 79% of staff receiving an annual appraisal over the previous 12 months. Malvern ward had the highest, with an average of 87% staff receiving an annual appraisal. Managers told us that access to accurate appraisal data was affected by the limitations of the electronic systems used. The Trust target is 90%. They also described changes of management which also contributed towards a delay in completing appraisals.

Our findings

Managers did not always support staff through regular and constructive clinical supervision of their work. The clinical supervision compliance rate for the service in the 12 months prior to the inspection was 68%. Eden ward had the highest compliance with 80% and Rainbow ward had the lowest at 49%. Managers cited the impact of Covid-19, long-term sickness, and issues with competency and performance as factors that affected timely supervisions.

Managers did not make sure staff attended regular team meetings and staff told us there were no regular meetings at ward level across the service. We reviewed a sample of ward governance meetings but saw that these were only attended by managers or senior clinical staff. Staff told us they did not always get the opportunity to raise issues or concerns. They also said they were not always kept informed of decisions or changes made by management, and some staff said they didn't feel listened to. This would impact on the morale of staff working with people that in turn would lead to poor morale on the ward.

Managers mostly ensured staff had the right skills, qualifications and experience to meet the needs of the people in their care, including bank and agency staff. There was evidence that managers identified staff training needs. Some staff told us that they were given the time and opportunity to develop their skills and knowledge. They described training courses available to them including positive behavioural support plan diplomas, advanced practitioner courses and phlebotomy training. The service also delivered specialised training on learning disabilities and autism. However, some health care assistants told us that the needs of people meant they had to spend long periods on observation which impacted their input into multidisciplinary discussions and how they delivered care to people. This was also highlighted by the lack of activities as activity workers were often included within the numbers and unable to use their skills to support people with individual or group activites.

Managers recognised poor performance, could identify the reasons and dealt with these. The managers we spoke with understood the performance management policy and could described how they used this.

Managers were in the process of recruiting and training of volunteers to work with people in the service. The service was piloting a 'buddy project' through commissioners of the service whereby people who had previously been in long-term segregation visited people currently on the ward, who were in long-term segregation, to engage with them and provide support.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss people and improve their care. Staff told us they invited people to these and that some people chose to attend them. We regularly saw Doctors on the ward who were engaged with people who use the service.

Staff made sure they shared clear information about people and any changes in their care, including during handover meetings. We had sight of handover documents which set out changes to risk levels, recent incidents, and general summaries.

Ward teams had effective working relationships with other teams in the organisation. In particular, staff described regular liaison and support from the risk management and patient safety teams. Ward teams had effective working relationships with external teams and organisations and staff described how care coordinators supported the discharge process.

Our findings

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 peoples' rights to them.

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice from the mental health legislation team. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

People had easy access to information about independent mental health advocacy and people who lacked capacity were automatically referred to the service. We saw information on display on the wards about how to contact the independent mental health advocate (IMHA). People told us they understood that advocacy support was available, and some people chose to make use of this. There was also an open clinic twice a week for people to seek support from a general advocacy provider.

Staff explained to each person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the person's notes each time.

Staff determined the frequency that rights were revisited individually with people and told us that most people had been detained for some time and had a good understanding of their rights and legal status.

Staff made sure people could take section 17 leave from the hospital when this was agreed with the Ministry of Justice. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. There were T3 certificates of second opinion on file where appropriate for people who lacked capacity or did not consent to treatment.

Staff stored copies of people's detention papers and associated records correctly and staff could access them when needed. This included keeping copies of medication authorisation certificates within the prescription charts

Care plans included information about after-care services available for those people who qualified for it under section 117 of the Mental Health Act. Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Staff told us these were completed by the mental health legislation team.

Good practice in applying the Mental Capacity Act

Staff supported people 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 people who might have impaired mental capacity.

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of the five principles of the Act. There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. This meant that when the Act was applied, people's rights were protected.

Our findings

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. People were sometimes discharged from the service and placed under a deprivation of liberty authorisation. Staff described how they liaised with the mental health legislation team and worked closely with clinical commissioning groups during the assessment process and supported with deprivation of liberty applications where necessary.

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision. The records we inspected showed that capacity for specific care and treatment decisions was routinely assessed and recorded.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Not all staff treated people with compassion and kindness. However, staff respected people's privacy and dignity. They also understood the individual needs of people and supported people to understand and manage their care, treatment or condition.

Staff gave people help, emotional support and advice but most people told us staff were overworked, which meant they weren't always able to be responsive to people's needs or provide timely intervention, for example, people cited having to wait to speak with nurses. People also reported more compassion, kindness and better support from regular staff and said that some agency and bank staff did not always take the time to interact with them. Some people described agency staff as rude or said that they ignored them.

Staff were discreet. People said that staff knocked prior to entering their bedrooms and that they respected their privacy.

People were able to describe their treatment pathway, the support they required, who was able to help and what they needed to do to support their discharge. Staff supported people to understand and manage their own care treatment or condition. People said staff went through their care plans with them. Staff directed people to other services and supported them to access those services if they needed help.

Staff mostly understood and respected the individual needs of each person, but in some cases people said that agency staff didn't understand their needs due to them not regularly working on the ward.

The staff we spoke with said they felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people. Staff knew who the freedom to speak up guardian was and how to contact them.

Our findings

Staff followed policy to keep people's information confidential. This included using passwords to access electronic records and locking doors and cupboards containing confidential information.

Involvement in care

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

Involvement of people who use services

Staff introduced people to the ward and the services as part of their admission and people received a ward orientation. People were informed of the restrictions on the ward, for example access to the internet, and the use of camera functions on their mobile phones.

Staff involved people in and gave them access to their care plans and risk assessments. Staff documented that they had offered people copies of their care plans.

Staff made sure people understood their care and treatment and found ways to communicate with people who had communication difficulties. This included providing people with easy read versions of their care plans.

Staff involved people in decisions about the service, when appropriate. People were involved in a pilot to develop quality standards for secure services. People also sat on interview panels to recruit for vacancies on the wards.

People could give feedback on the service and their treatment and staff supported them to do this. Those people we spoke with mostly understood how they could do this. People described how they had told ward managers about the lack of activities, not enough staff, and the quality of the food. However, they felt that they had either not been listened to or staff above ward managers didn't support change.

There was a therapeutic meeting twice a day which enabled people to ask staff about planned activities and sessions or raise any concerns or issues they had.

Staff made sure people could access advocacy services. There was information on display about how to contact the service. We saw evidence of referrals to advocacy services in the records we reviewed.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. This included weekly carers contact calls, whereby staff provided family and carers with updates and invited them to contribute their views.

Staff helped families to give feedback on the service and we saw that carers were invited to meetings including ward rounds, care programme approach meetings and discharge planning meetings. However, none of the carers we spoke with said staff provided information on how to find the carer's assessment.

Our findings

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate.

Access and discharge

Staff planned and managed people's discharge well. They worked well with services providing aftercare and managed people's moves to another inpatient service or to prison. However, sometimes people had to stay in hospital when they were well enough to leave.

Bed management

At the time of the inspection, most of the wards were full or above 85% bed occupancy. Managers regularly reviewed the length of stay for people to try and prevent them from staying in hospital longer than they needed to.

Managers reviewed people's estimated date of discharge and arranged meetings with commissioners of the service and clinical commissioning groups to escalate delays. Managers also held escalation meetings to discuss and resolve barriers to discharge.

The service reported no current out-of-area placements and no people had been placed out of area in the six months prior to the inspection. However, as the service was a regional service for people who came from the West Midlands, it meant that people were not always close to home and families and carers sometimes had difficulty journeys to meet people who used the service. The admission of people from across the region was the clinical model for secure services' and the service said they worked in collaboration with regional commissioners and other regional providers to minimise disruption and limit the distance people were from their home setting.

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

People were moved between wards only when there were clear clinical reasons or it was in the best interest of the person. Staff did not move or discharge people at night or very early in the morning.

Discharge and transfers of care

People sometimes had to stay in hospital when they were well enough to leave due to a lack of appropriate placements. There were five people whose discharge was delayed on Malvern ward, and two people on Janet Shaw Clinic. Nevertheless, managers monitored the number of people whose discharge was delayed, knew which wards had the most delays, and took action to try reduce them. This included discussing and actioning barriers to discharge in escalation meetings.

People often had complex needs and managers described difficulties in finding appropriate placements for them. They said there were limited care providers who could meet the needs of people who used the service. Working with commissioners, the service had developed a specialist ward for people with autism who may have co-morbid mental

health and learning disability conditions. A further bespoke ward was being built to prepare people with autism to develop their independent skills and prepare them for a life in the community. The aim was not only for people to have the skills for independent living but demonstrate to commissioners and the local authority that their needs could be met in the community.

Staff carefully planned people's discharges and worked with care managers and coordinators to make sure these went well. Staff created discharge packs, including personalised service specifications, which were shared with staff at the receiving placement to ensure they understood the person's history and current needs.

Managers arranged for staff from potential providers to work with people on the wards prior to their discharge. The service also delivered training packages to staff from potential placement to enable them to take over peoples' care and said that discharge was only finalised once those staff had received the training.

Managers said they felt they were proactive throughout the discharge process and gave examples of how they worked with external stakeholders. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not support people's treatment, privacy and dignity. Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The feedback on the quality of food was poor. People could access snacks at any time, but ongoing staffing issues meant some people had to wait to access hot and cold drinks.

The environmental concerns on Janet Shaw clinic did not support people's dignity. The cleanliness of bedrooms and ward areas, and the quality of some of the furnishings including walls and flooring did not create an environment that promoted recovery.

Some rooms were locked and people required assistance to access these. Each person had their own bedroom, which they could personalise and had a secure place to store personal possessions.

The service had quiet areas and a room where people could meet with visitors in private and make phone calls without interruption or being overheard. The service had an outside space that people could access. People had access to gardens and across the low secure wards they had access to large open spaces and gym equipment. The Janet Shaw Clinic had large open spaces however the space was poorly used. Previously used vegetable beds were overgrown, there was debris on the ground including rocks and screws attached to wood, and the shed that stored equipment was in poor condition. We saw people using the outdoor space to take fresh air.

People could access snacks at any time. Some people were risks assessed as being able to make hot and cold drinks themselves in the occupational therapy kitchen. The main kitchen was locked which meant those people without access to the occupational therapy kitchen could not access hot and cold drinks without asking staff as the kitchen. Due to staffing issues, people told us that they had to wait to get a drink. The service offered a variety of food. However, feedback on the food was generally poor. Some people described the food as average whereas other people told us they did not like the food and described it as poor quality and unhealthy. People described having to wait for their food as often staff were not available which meant food was sometimes cold by the time they were able to eat, Some people told us they did not eat the food and instead ordered takeaways or ate snacks they had purchased themselves.

Our findings

People's engagement with the wider community

Staff did not always support people with activities outside the service, such as work, education and family relationships.

Staff and people on the wards described a lack of access to opportunities for education and work. They said that access to reading and writing courses and attendance at the recovery college had been impacted due to the outbreak of Covid-19.

People described how continued short staffing meant there was no one available to transport people in the services' minibuses. This further impacted people's ability to engage with the wider community. We were concerned that these issues did not adhere to the Right Support, Right Care, Right Culture model of care which specifies that providers should have a strong focus on continuously developing people's ownership of meaningful activities, independence and quality of life.

However, despite staff shortages, we did not see any people being denied leave into the grounds or the community. Leave may have been delayed for part of the day but staff worked hard to ensure that people took their leave.

Staff said the service was in the process of recruiting a manager for activities and engagement. They told us recruitment into this new role would address some of the issues around access to work and education and that individual in post would have overall responsibility for section 17 leave.

Staff helped people to stay in contact with families and carers. People told us they were able to speak to their family or carers regularly over the telephone or using video call facilities.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. This included Makaton, a language programme that uses signs together with speech and symbols to help people to communicate. People had access to a speech and language team who were embedded in the multidisciplinary team and visible on the wards. They supported staff to communicate well with people.

Staff made sure people could access information on treatment, local services, their rights and how to complain. The service had information leaflets available in languages spoken by people on the wards and in the local community. Managers made sure staff and people on the wards could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individuals.

People had access to spiritual, religious and cultural support and there were multifaith rooms available on site for people to use.

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.

Our findings

People on the wards knew how to complain or raise concerns. The service displayed information about how to raise complaint to the trust and this information was available on the public website. However, two out of three carers said they did not know how to complain or did not know they had a right to complain.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Managers attended safety and quality meetings which they said enabled them to review and monitor complaints at ward level.

Managers could give examples of the types of complaints they received and action they had taken as a result. However, some people described how they had told managers about a lack of activities, or complained about the food, but said that they didn't always feel listened to.

Staff protected people who raised concerns or complaints from discrimination and harassment. Staff knew how to acknowledge complaints and people 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. There was also a process in place for people to complain informally or raise concerns though the 'I want great care' initiative. This enabled people to feedback on a number areas which were reviewed and investigated by the patient advice and liaison service who then provided a response. The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Inadequate ↓↓

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders did not always have the skills, knowledge and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service and approachable for people and staff.

Some staff were complimentary about their immediate managers and leaders. They described them as approachable, visible and supportive and said there was an 'open door policy' on the ward. We saw that managers sometimes supported with clinical duties during busy periods.

Staff described how a lack of team meetings meant they couldn't always raise issues or concerns with their immediate managers which they said impacted staff morale.

Senior managers were generally less visible. Some staff said senior managers rarely visited the wards or spoke with staff. Other staff said they did not know who the senior leaders were. Staff told us that executive level information was rarely shared. We shared this feedback with leaders who told us that the Trust published a newsletter three times each week which included trust wide and national updates, and a blog from a member of the executive team. Leaders also said that the trust held regular video calls which were open to all staff and covered a broad range of topics relevant to staff.

Our findings

The trust's quality improvement plan had identified environmental concerns on Janet Shaw Clinic in March 2022. However, as the concerns had not been addressed at the time of the inspection we were not assured that leaders had sufficient oversight of the concerns or took appropriate action to address these. It was also not clear whether the concerns were being managed by the facilities team or the clinical team, and whether communication between the teams had taken place to address the concerns.

Vision and strategy

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

The staff we spoke with understood staff the trusts vision and values and could provide examples of how they promoted these on the ward.

Two staff we spoke with did not believe that leaders above ward manager level and the executive team promoted the trust values in their own actions and behaviours. Staff cited not having a say in care and treatment as a reason for this.

Culture

Staff felt respected, supported and valued by their immediate managers. 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.

Some staff said they didn't feel supported and described the challenges of regularly working extra hours or additional shifts on the wards. It was often difficult to speak with staff on the Janet Shaw Clinic because their caring responsibility meant they had little time to do so. People did speak about regular staff and how overworked they were, with one person explaining how they often could not go to the toilet due to undertaking constant observations, and reflecting that staff are human beings as well so need their breaks. People described good relationships with regular staff and spoke of respect for them in supporting them with the culture of bullying on the ward they had described.

Despite the staffing issues across the service, most staff spoke very positively about how they worked as a team and described good teamwork, with people's care being the priority.

Staff said they felt able to raise concerns to managers or senior managers and could do so without fear. The staff we spoke with knew who their freedom to speak up guardian was.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were managed well.

Managers did not make sure staff attended regular team meetings and staff told us there were no regular meetings at ward level across the service. Staff told us they did not always get the opportunity to raise issues or concerns. They also said they were not always kept informed of decisions or changes made by management, and some staff said they didn't feel listened to.

Managers monitored key performance indicators, mandatory training, staff supervision and appraisals. There was evidence of oversight by senior management which included a review of key performance indicators during safety and quality meetings. However, the service was not meeting their own targets for some key performance indicators, in particular, appraisals and supervisions.

Our findings

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care and used that information to good effect.

CQC raised concerns about staffing, the ward environment, and a poor culture to local managers and trust senior leaders in the first week of the inspection. We returned to the Janet Shaw Clinic to identify progress and were not assured that local leaders understood the seriousness of our concerns. We identified additional concerns about cleanliness, the environment and infection prevention control processes and again spoke with trust senior leaders. At this point, those leaders assessed the Janet Shaw Clinic and immediately detailed an action plan that was shared with CQC. This included a deep clean of the wards, ordering of furniture and maintenance work to mitigate risk.

We reviewed the quality improvement plan for the service and saw that staff had implemented actions to address concerns. Actions had completion dates and staff were mostly meeting timescales for completion or documenting the reason for delays. The Trust was aware of the need to improve its supervision performance and had identified this as an action in the quality improvement plan.

The service recorded all incidents of restraint on an incident reporting system which recorded the type of safety intervention used. All incidents of prone restraint were reviewed at the Restrictive Practice Group, to identify lessons learned. The Restrictive Practice Group used incident data to identify people who had high numbers of safety interventions, to review incidents for lessons learned, themes and how they could support those individuals.

We saw that the quality improvement plan recorded the ongoing staffing issues and that leaders were cited on these. However, it did not appear leaders had taken appropriate action to keep people safe at all times. In addition, the quality improvement plan did not identify the concerns around the culture and people's fear of bullying and intimidation.

Staff could not always access the electronic records easily due to issues with the internet quality across the site. Staff told us that the internet was not always accessible in meeting rooms or quiet rooms throughout the wards. This meant they couldn't always access care records, safe staffing data or health rotas, and also told us this impacted their ability to make use of video calls to liaise with external agencies.

The service had a risk register in place which was subject regular review and monitoring during safety and quality meetings.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Managers and staff monitored the effectiveness of their service to enable quality improvement. Staff told us that the risk management team produced regular incident reports which were circulated to managers and staff to enable themes and trends to be identified.

Engagement

Managers engaged actively 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.

Our findings

Staff obtained background or historical information for people prior to admission to help inform care and treatment. They also shared information on people with external teams prior to transfer or discharge. This included working closely with staff at residential placements and care homes.

There was evidence that managers liaised with commissioners of the service, local authorities, clinical commissioning groups, and other health care providers. However, the poor internet quality sometimes impacted staff's ability to liaise with external stakeholders.

Staff from other health and social care providers were invited to discharge meetings, and section 117 after care meetings where appropriate.

Learning, continuous improvement and innovation

Managers used quality improvement methodologies to implement changes and enhance care and systems. The managers we spoke with provided recent examples of these quality improvement initiatives. For example, one ward manager used a ward improvement plan which included actions to address care planning, appraisals and supervision, and ward security including the process for managing the unit keys.

Our findings

Areas for improvement

MUSTS

- The trust must ensure that it has enough qualified and unqualified nursing staff to keep people safe from avoidable harm. (Regulation 18(1))
- The trust must ensure that it safeguards people from bullying, intimidation and the threat of violence (Regulation 13(3))
- The trust must ensure that all premises and equipment are clean, secure, suitable for the purpose they are used, and properly maintained. (Regulation 15(1))
- The trust must ensure that it has effective systems in place to ensure that cleaning records and infection prevention control audits are completed in a timely manner, are fit for purpose, and identify and address areas of concern. (Regulation 17(2)(b))
- The trust must ensure restrictive interventions are only used as proportionate responses to identified risks (Regulation 13(4)(b))
- The trust must ensure that staff adhere to best practice standards, and complete seclusion and long-term segregation reviews within prescribed timescales (Regulation 12(2)(a))
- The trust must ensure that staff can access the internet to enable them to view and update care records and liaise with internal and external stakeholders where required (Regulation 17(1)
- The trust must ensure that it has senior leaders have effective oversight and can monitor and mitigate against risks relating to the health, safety and welfare of service users. This includes ensuring that quality improvement plans are effective in identifying and addressing these risks (17(2)(b))
- The trust must ensure that it has sufficient staff within the occupational therapy team to meet clinical need and complete specific assessments such as sensory assessments in a timely manner. (Regulation 18(1))

SHOULDS

- The trust should ensure staff receive all statutory and mandatory training required to effectively carry out their duties.
- The trust should ensure staff meet regularly as a team to discuss issues and raise concerns.
- The trust should ensure that staff provider carers with information about a carers assessment.
- The trust should ensure that staff receive supervision and appraisals in a timely manner.
- The trust should ensure it provides staff with the time to develop their skills to support care delivery to people who use the service.
- The trust should ensure that activity workers function effectively in their roles to meaningfully occupy and support the care pathway of people.

Our inspection team

We conducted an unannounced comprehensive inspection.

We visited 4 wards

We conducted the following tasks:

- Looked at the ward layout and environments
- spoke with 25 staff
- reviewed 10 care records
- reviewed 11 prescription charts
- spoke with 14 people who use services and 3 carers
- conducted observation in communal areas
- observed a multidisciplinary team meeting
- observed a staff morning meeting
- observed people at mealtimes
- looked at a range of documentation including policies, standard operating procedures, reports and meeting minutes.

What people who use the service say

We spoke with 14 people who user services and three carers. Feedback about care and treatment, activities and staff were mixed.

People told us the wards were short staff and there was too much reliance on bank and agency staff. People said there wasn't enough to do on the wards and described a lack of activities

Some people were positive about staff and said they worked hard, were caring and treated them with kindness and compassion. Other people said staff did engage with them or didn't have the time to do so.

People said they saw their consultant regularly. People described a range of group and individual psychology sessions available to them.

Feedback on the quality and variety of food was generally poor and some people told us they preferred to order takeaways or eat snacks they had bought themselves.

Carers mostly said staff kept them informed of care and treatment decisions. However, they said that they weren't always informed of incidents that had taken place.

Some carers were unaware of the process for making a complaint.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance
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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care