Suttons Manor

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Suttons Manor as good because:

- Wards had sufficient numbers of nurses on all shifts. We reviewed the duty rotas for the previous six weeks. These showed that the provider was meeting staffing establishment numbers. Staff had received up-to-date mandatory training. The current mandatory training compliance rate for the service was 80%. The provider had a mandatory training action plan to improve mandatory training to meet the provider's target of 95%. Staff received supervision and an annual appraisal in line with the provider's policy. We reviewed the supervision and appraisal records and found that staff compliance was 100%.
- Staff knew how to use the whistleblowing policy. Staff we spoke to told us that they would feel confident in raising concerns without fear of victimisation. Staff told us they felt that managers would deal with concerns appropriately. Staff are open and transparent and explained to patients when things went wrong. We reviewed the incident reports the saw evidence within care records that staff had discussed with patients when things went wrong.
- Patients received a comprehensive and timely assessment of their needs. Staff used the information gathered during this assessment period to formulate care plans. Patients had good access to physical healthcare. The provider employed a physical health care nurse who worked at the service three times a week. The provider also had a GP who visited the service once a week. Patients' were involved in the planning of their care. Care plans had a section where patients could comment. Patients attended care review meetings where they could discuss their care plan and any changes they felt needed to be made. Families and carers were involved in patient care. The provider offered family and carers one-to-one sessions and they also invited them to patients' care reviews.
- Patients knew how to complain. Staff provided patients with information on how to make complaints within the admission pack. Staff knew how to handle complaints appropriately. Staff we spoke to were able to explain what action they would take if a patient made a formal complaint to them.
- The food was of good quality. All the food was prepared on site each day. Patients we spoke to told us that the food was excellent and there was always a choice if patients did not like what was on the daily menu.

However:

- There were ligature points throughout the wards, including the bedrooms and the bathrooms. The provider had completed a ligature audit and risk assessment. However, this did not include all ligature anchor points and the actions staff would take to mitigate each risk.
- Staff did not always update risk assessments following incidents. Staff did not always document all identified risks within the risk assessments such as when patients were subject to multiagency public protection arrangements. Staff did not complete seclusion documentation appropriately. Staff had not documented 15 minute checks on a patient in seclusion.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards	Good 	Forensic inpatient/secure wards

Summary of findings

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Good

Suttons Manor

Services we looked at

Forensic inpatient/secure wards;

Summary of this inspection

Background to Suttons Manor

Suttons Manor provides treatment and rehabilitation for mentally disordered men with a mental illness and/or personality disorder often referred for care by the criminal justice system. They have 26 beds.

Care is provided over two wards. Westleigh ward is a low secure service providing care for adults aged over 50 years. There are 13 beds on this ward and at the time of inspection, all the beds were occupied.

South Weald ward provides a specialist low secure forensic inpatient service to those aged over 50 years. This ward also had 13 beds, 12 were occupied at the time of inspection.

Lewys Savill has applied to the Care Quality Commission to become the registered manager and Pat Khek is the controlled drugs accountable officer.

The location is registered to provide the following registered activities;

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

• Diagnostic and screening procedures.

• Treatment of disease, disorder or injury

This service was last inspected by the CQC in 2016. We found no breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Our inspection team

The team that inspected the service comprised of an inspection manager, 2 inspectors, and a specialist advisor who has experience working in forensic services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with five patients who were using the service;
- spoke with three carers of patients;
- spoke with the registered manager and managers for each of the wards;
- spoke with eight other staff members; including doctors, nurses, health care assistants, occupational therapist, and social worker;
- attended and observed a hand-over meetings;
- looked at eight care and treatment records of patients;

Summary of this inspection

- carried out a specific check of the medication management on both wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us that they were happy with their care and that staff were polite and respectful and treated them with dignity and respect.

Patients told us that staff responded to them in a timely manner if they needed to talk to someone. Staff dealt well with difficult situations on the wards that needed to be managed safely. Patients told us that they felt safe.

Patients said that the therapeutic programme was comprehensive, they enjoyed the activities and they were beneficial.

Patients told us they enjoyed the food that was freshly prepared and they were able to have a say in the menu, and the design of the service as whole.

Carers told us that staff were polite, kind, and respectful and kept them informed of their loved one's care.

Carers told us that they felt involved in their loved one's care. Staff invited them to care programme approach meetings and updated them on any changes of need.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There were ligature points throughout the wards, including the bedrooms and the bathrooms. The provider had completed a ligature audit and risk assessment. However, this did not include all ligature anchor points and the actions staff would take to mitigate each risk.
- Staff did not always update risk assessments following incidents. Staff did not always document all identified risks within the risk assessments such as when patients were subject to multiagency public protection arrangements.
- Staff did not complete seclusion documentation appropriately. Staff had not documented 15 minute checks on a patient in seclusion.

However,

- All areas of the wards were clean and tidy. The furnishings were in good condition and well maintained.
- Wards had sufficient numbers of nurses on all shifts. We reviewed the duty rotas for the previous six weeks. These showed that the provider was meeting staffing establishment numbers.
- Staff had received up-to-date mandatory training. The current mandatory training compliance rate for the service was 80%. The provider had mandatory training action plan to improve mandatory training to meet the provider's target of 95%.

Are services effective?

Good

We rated effective as good because:

- Patients received a comprehensive and timely assessment of their needs. Staff used the information gathered during this assessment period to formulate care plans.
- Patients had good access to physical healthcare. The provider had a physical health care nurse who attended the service three times a week. The provider also had a GP who visited the service once a week.
- Staff received supervision and an annual appraisal in line with the provider's policy. We reviewed the supervision and appraisal records and found that staff compliance was 100%.
- The provider offered psychological therapies recommended by the National Institute for Health and Care Excellence. These included cognitive behaviour therapy and mindfulness.

Summary of this inspection

- Staff assessed and met patients' nutritional and hydration needs. Kitchen staff told us that they kept a file which indicates patients' likes and dislikes and any specialist dietary requirements, such as soft or diabetic diet.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion, dignity, and respect. We observed positive engagement between staff and patients. Patients told us staff were kind, caring and compassionate.
- Staff demonstrated a good understanding of patients' needs. Staff were able to explain the needs of individual patients and how they met these needs.
- Patients were involved in the planning of their care. Care plans had a section where patients could comment. Patients attended care review meetings where they could discuss their care plan and any changes they felt needed to be made.
- Families and carers were involved in patient care. The provider offered family and carers one-to-one session and they also invited them to patients' care reviews.

Are services responsive?

Good

We rated responsive as good because:

- The provider had a full range of rooms and equipment to support treatment and care. These included a clinic room, therapy kitchen, the spiritual room, family visiting room, gym and therapy rooms.
- Patients were able to personalise their bedrooms. Patients were able to bring in personal items such as pictures, posters, and bedlinen to personalise their bedrooms.
- The food was of good quality. All the food was prepared on site each day. Patients we spoke to told us that the food was excellent and that there was always a choice if patients did not like what was on the daily menu.
- The provider had made adjustments for people requiring disabled access. Both wards were on the ground floor and there was a lift to enable disabled people to access the first floor to attend therapeutic activities and care reviews.
- Patients knew how to complain. Staff provided patients with information on how to make complaints within the admission pack. Staff knew how to handle complaints appropriately. Staff we spoke to were able to explain what action they would take if a patient made a formal complaint to them.

Summary of this inspection

Are services well-led?

Good

We rated well-led as good because:

- The provider had systems in place to monitor staff compliance with mandatory training. The provider used an online dashboard that highlighted the percentage of staff that had completed each mandatory training course.
- The provider had systems in place to monitor staffs compliance with supervision and appraisals. The provider used dashboards to monitor staff compliance with supervision and appraisals.
- Staff were able to maximise their time on direct care activities. We saw evidence throughout the inspection that staff spent time on the wards engaging with patients rather than undertaking administrative tasks.
- Staff knew how to use the whistleblowing policy. Staff we spoke to told us that they would feel confident in raising concerns without fear of victimisation. Staff told us they felt that managers would deal with concerns appropriately.
- Staff were open and transparent and explained to patients when things went wrong. We reviewed the incident reports the saw evidence within care records that staff had discussed with patients when things went wrong.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Twenty-four of the 25 patients were detained under the Mental Health Act.
- Eighty percent of staff had received training in the Mental Health Act. Staff completed an online training course which covered the Mental Health Act and the code of practice.
- We saw evidence in the care records that staff read patients their rights under the Mental Health Act on a monthly basis.
- Staff received and examined Mental Health Act papers appropriately. Staff checked all paperwork to make sure it was completed properly and met the Mental Health Act code of practice standards.
- Second opinion appointed doctors had assessed patients' ability to consent to treatment where appropriate and the necessary documentation completed.
- Patients had access to independent mental health advocates. The provider used a local advocacy service to provide support to patients

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had received training on the Mental Capacity Act. Staff we spoke to had a good understanding of the Mental Capacity Act. Staff were able to explain what action they would take if they suspected a patient lacked capacity.
- The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards.
- Staff assessed capacity and capacity to consent appropriately. Staff told us that the doctor completed capacity assessments with another of member of staff.
- Staff supported patients who lacked capacity to make decisions in their best interest. If a patient lacked capacity, staff would arrange a best interest decision meeting. This included family and care coordinators or any other relevant person involved in the patient's care.
- The provider had access to an independent mental capacity advocates. The provider used a local advocacy service to provide the support patients.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- The ward layout did not allow staff to observe all areas of the ward. There were blind spots within the bedroom corridors of both wards. The provider had mitigated the risks of the blind spots with mirrors to allow staff to observe all areas of the ward. However, on Westleigh Heights ward, one mirror had been placed in a position which made it difficult for staff to easily see down the end corridor.
- There were ligature points throughout the wards, including the bedrooms and the bathrooms. These included window handles, wardrobes, paper towel and soap dispensers. Each ward had two bedrooms that had been fitted with anti-ligature fixtures. The service used these rooms for patients if they were a high risk of self-harm. The provider had completed a ligature audit and risk assessment. However, this did not include all ligature anchor points and the actions staff would take to mitigate each risk was not always completed. The provider had a ligature action plan. However, this did not include all areas of the ward such as a bathroom on Westleigh Heights ward. The ligature risk assessment stated that the provider planned to remove various ligature anchor points. The completion date for this was 30 December 2017. Senior staff told us they had not completed this work, as they were waiting for some replacement parts.
- The service complied with the Department of Health guidance on mixed sex accommodation as both wards only admitted male patients.
- Both wards had a fully equipped clinic room. Each contained all necessary equipment to monitor patient's physical health. Resuscitation equipment was available in easily accessible grab bags. Staff cleaned and checked physical observation and resuscitation equipment on a weekly basis. We reviewed the audits and saw that this was happening, in line with the provider's policy.
- The seclusion room met with required standards as stated in the Mental Health Act code of practice. The seclusion room was on South Weald ward. However, it was easily accessible for staff on Westleigh Heights ward. Staff were able to clearly observe the patient in all areas of the room. There were toilet and shower facilities. Staff were able to maintain communication with the patient through the two-way communication system. The seclusion room had a clock to allow patients to remain orientated to time. Staff told us they could control the temperature of the room. However, the day of inspection it was very warm in the room then staff told us that they would have to contact maintenance to reduce the temperature as there was a problem with the system.
- All areas of the ward were clean and tidy. The furnishings were in good condition and well maintained. Cleaning staff cleaned the ward areas on a daily basis. We checked the cleaning audits and saw that staff completed these appropriately and in line with the provider's policy.
- There were good infection control practices in place. Staff had access to hand washing facilities in the staff toilets and clinic room. Staff used protective clothing when providing care and disposed of these safely in contaminated waste bins. We observed appropriate hand washing by staff after they had provided care.

Good

Forensic inpatient/secure wards

- The provider regularly maintained all equipment. All electrical equipment had been portable appliance tested (portable appliance testing is a routine test to make sure electrical appliances are safe).
- The provider completed an environmental risk assessment. We reviewed this and found that it included all areas of the hospital. It also included the garden and horticultural area and patient use of garden machinery. The provider reviewed this on an annual basis.
- Staff had access to personal safety alarms. There were alarm panels around the wards that displayed where staff had activated the alarm. This enabled colleagues to easily identify where they needed to respond. Patients had a nurse call system in their room, so they could summon assistance.

Safe staffing

- The provider's whole time equivalent establishment of nurses was 12. Their whole time equivalent establishment of nursing assistants was 27. The provider currently had two registered nurse vacancies and 18 nursing assistant vacancies.
- The provider had estimated the number of staff on each shift by using the safe staffing tool. This tool enabled senior staff to assess patient acuity and dependency and ensure that nursing establishments reflect patients' needs.
- Wards had sufficient numbers of nurses on all shifts. Westleigh Heights ward had an establishment of two nurses and three health care assistants per shift and the South Weald ward had an establishment of two nurses and four health care assistants per shift. We reviewed the duty rotas for the previous six weeks. These showed that the provider was meeting staffing establishment numbers.
- The provider used agency and bank staff appropriately. Agency and bank staff were block booked and used regularly. Agency and bank staff were included in staff training and supervision to ensure that their performance met with the provider's standards.
- Ward managers were able to adjust staffing levels to take account of the ward activity levels. We saw evidence in the duty rotas that the provider brought in extra staff to manage increased patient observations, or to support with patients' leave or access to appointments.
- There were qualified nurses present on the wards at all times. Each ward had a minimum two qualified nurses on each shift. If one of the qualified nurses had to attend a care review meeting, there will always be one qualified nurse on the ward.
- There was enough staff so that patients could have regular one-to-one time with their named nurse. Patients we spoke to told us that there was always staff available if they wished to have time to talk. Staff also told us that they had regular one-to-one time with their allocated patients and that they scheduled this as part of patient's therapeutic programme.
- Staff never cancelled leave or ward activities due to staffing issues. Staff told us that if they were unable to take the patient on planned schedule leave due to issues such as high ward activity, then they would rearrange this at the earliest convenient time.
- Wards had enough staff to carry out physical interventions safely. Each ward had a staff member dedicated as security nurse who responded to alarms and assisted where necessary.
- The provider had adequate medical cover during the day and night. The provider employed a consultant psychiatrist, and a specialist doctor. There was an on-call doctor out of hours, who worked between Suttons Manor and another of the provider's hospitals.
- Staff were up-to-date with mandatory training. The current overall mandatory training compliance for the service was 80%. The provider had mandatory training action plan to improve mandatory training to meet the provider's target of 95%. We reviewed the action plan which highlighted they had allocated staff on to training courses in the near future, which would bring compliance up to the providers target.

Assessing and managing risk to patients and staff

- The service had one incident of seclusion on South Weald ward in the last six months. We reviewed the seclusion documentation for this incident. We found that staff had not completed the paperwork appropriately and in line with the provider's policy.
- The provider had one episode of restraint on South Weald ward in the last six months. We reviewed patient file and saw that staff had documented this appropriately and completed incident form. The service does not use prone restraint.
- Staff undertook a risk assessment of patients upon admission. We reviewed the care records of eight

patients. We found that one patient had not had his risk assessment updated following an incident. In two patients' risk assessments, staff had not clearly documented that they had multi-agency public protection arrangements in place (multi-agency public protection arrangements are to ensure the successful management of violent or sexual offenders). We also found in one patient's record that not all identified risks were included in their risk assessment.

- The service used recognised risk assessment tools. Staff completed a historical, clinical and risk management scales version 20 risk assessment upon admission. This is a risk assessment tool that gathers historic clinical risk information. Staff also used the short-term assessment of risk and treatability tool. This is a concise clinical guide to the assessment of short-term risk for violence and treatability.
- The provider did not operate any blanket restrictions.There were restrictions on patients smoking if they did not have appropriate leave.The hospital was a no smoking site and patients would have to go off grounds to smoke. Staff told us that these restrictions were in place to promote engagement with the therapeutic programme. However, staff told us that patients could go out and smoke outside of these times, upon request, if they had appropriate leave to do so.
- Informal patients were able to leave the hospital at will. The service had one patient who had recently become informal. We spoke to them and they were aware of their rights to leave the hospital when they desired.
- The service had good policies and procedures for the use of observations. We reviewed the observation policy. This showed that staff followed the policy appropriately and only used observation as a means to reduce the risk of harm to self or others.
- Staff only used restraint after de-escalation had failed. The service had only had one incident of restraint in the last 12 months. Care records showed that staff were able to successfully de-escalate patients when they became agitated, or aggressive.
- Staff used seclusion appropriately and followed best practice. However, seclusion records were not always completed appropriately. We reviewed the records of a recent incident of seclusion. Staff had not completed records of their 15 minutes observations.
- Staff were trained in safeguarding and knew how to make a safeguarding alert when appropriate. Staff compliance with safeguarding training was 92% for both safeguarding adults and safeguarding children.
- The provider had good medicines management procedures in place. Staff kept medication locked in cupboards and a medicines trolley in the clinic room. Staff kept controlled drugs in a separate locked cupboard. The nurse in charge of each shift was responsible for the keys to the medication cupboards.
- The provider had a contract with a local pharmacy that provided medication. A pharmacist would attend the wards each week to audit medication and to restock the medication cupboards. We checked the records of controlled drugs. We found that staff were managing this appropriately and that records were signed by two members of staff.

Track record on safety

- The provider reported five serious incidents in the past 12 months. These included medication errors and patient on patient assaults which they reported to the Care Quality Commission.
- There were no adverse events in the past 12 months.

Reporting incidents and learning from when things go wrong

- All staff we spoke to knew how to report incidents and what they needed to report as an incident. Staff reported incidents on an online reporting system. All staff had access to this system, including bank and agency staff. We reviewed recent incident reports. This showed that staff were reporting incidents appropriately and in line with provider's policy.
- Staff were open and transparent and explained to patients when things went wrong. Incident reports showed that staff explained to patients when things went wrong such as if staff had made a medication error.
- Staff received feedback from the investigation of incidents. Staff told us the provider shared lessons learned from incidents during handovers and team meetings. We reviewed the minutes of team meetings and saw that this included discussion on lessons learned from incidents.
- Staff and patients received a debrief following serious incidents. Staff told us they have a hot and cold debrief. The hot debrief happened straight after incidents,

where staff discussed what happened and what went well, and what they would do differently next time. The cold debrief happened after the incident had been reviewed. Staff discussed how they would implement any lessons learned identified.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Patients received a comprehensive and timely assessment of their needs. Upon receipt of a referral, the doctor and another member of staff completed the initial assessment. If the patient's needs met the hospital's criteria, they would have a further period of assessment upon admission. Staff used the information gathered during this assessment period to formulate care plans. We reviewed eight patients' care records and found assessments were comprehensive and identified the needs of patients.
- Patients received a physical examination upon admission. Patients' records showed ongoing monitoring of physical health. The service had a physical health nurse who attended three days a week and was responsible for managing the patients' general physical healthcare needs. The service also had a GP who attended once a week to monitor patients' physical health needs.
- Care records contained up to date, personalised, and holistic care plans. Care plans covered a range of needs, including mental health needs, physical health needs, activities of daily living, and engagement with the therapeutic programme. Care plans covered a 12 week cycle and at the end of this period, they were reviewed. We saw evidence that staff updated care plans if there was a change of needs.
- Information needed to deliver care was stored securely and was available to all staff including bank and agency staff. The provider used an electronic recording system for patient records. The provider also kept paper copies of important information such as risk assessments and care plans. These were kept locked in the staff office. This meant that staff had access to important information in the event of a technological breakdown.

Best practice in treatment and care

- Staff used National Institute for Health and Care Excellence guidelines when prescribing medication. Staff used guidelines around the prescribing of antipsychotic medication and monitoring. Staff told us they had access to all National Institute for Health and Care Excellence guidance. The local pharmacy did a weekly audit of prescribing.
- The provider offered psychological therapies recommended by the National Institute for Health and Care excellence. These included cognitive behaviour therapy and mindfulness. The provider offered a comprehensive therapeutic programme, including horticulture groups, maths and English groups, and activities of daily living skills development. Patients were also able to take part in real work opportunities at the local care farm.
- Patients had good access to physical healthcare. The GP could refer to specialists, where necessary, such as to diabetes specialist nurse or podiatrists.
- Staff assessed and met patients nutritional and hydration needs. Kitchen staff told us that they kept a file for each patient which indicated their likes and dislikes and any specialist dietary requirements such as soft or diabetic diet. Kitchen staff used this information to plan menus.
- Staff used recognised rating scales to assess and record patient outcomes. The provider used Health of the Nation Outcome Scales to monitor patients' progress during their admission.
- Staff participated in clinical audits. Staff were responsible for completing care plan, risk assessment, care programme approach, and observation in engagement audits. We reviewed these audits and saw that staff were completing them appropriately and in line with provider's policy. Managers were able to monitor clinical audits with use of their online dashboard system.

Skilled staff to deliver care

Good

Forensic inpatient/secure wards

- The provider employed a full range of mental health disciplines. These included nurses, support workers, occupational therapists, doctors, psychologists, and a social worker.
- Staff had the necessary experience and qualifications. We reviewed staff records and saw that staff had the appropriate experience and qualifications to perform their roles.
- Staff received an appropriate induction. Staff completed an induction programme over the first two weeks of their employment and completed an induction checklist. This included completing all mandatory training. Support workers were encouraged to take part in the care certificate as part of their ongoing development.
- Staff received supervision in line with the provider's policy. We reviewed the supervision records and found that staff compliance with supervision was 100%. Staff also received an annual appraisal of their performance. We reviewed the appraisal records which showed that staff were 100% compliant.
- Staff had access to specialist training to help them perform their role. This included dementia training, security, risk, violence and aggression. The provider did not provide details of staff who had completed specialist training.
- Staff told us that poor performance would be dealt with through supervision and appraisals. However, there had been no issues of staff poor performance in the past 12 months.

Multi-disciplinary and inter-agency team work

- Staff attended multidisciplinary team meetings each morning. We attended one of these meetings. During this meeting, staff discussed events from the previous day. Staff discussed various patients' care as well as any incidents. Staff also attended weekly multidisciplinary team meetings where they discussed individual patients' care and treatment.
- There were effective working relationships with teams and other organisations. Staff told us they had very good working relationship with the local authority safeguarding team. They had named contacts within the teams who attended the service for monthly safeguarding meetings.

Adherence to the MHA and the MHA Code of Practice

- Staff received and examined Mental Health Act papers appropriately. Staff checked all paperwork to make sure staff had completed it properly and that it met the Mental Health Act code of practice standards.
- The service was in the process of employing a Mental Health Act administrator.
- Staff kept clear records of section 17 leave granted to patients. Staff completed the form prior to patients going out and section 17 leave. This included a description the patient, any risks, and a crisis plan if the patient failed to return.
- Eighty percent of staff had received training in the Mental Health Act. Staff completed an online training course which covered the Mental Health Act and the code of practice. Staff had a good understanding of the Mental Health Act and code of practice. Staff were aware of patients' status under the Mental Health Act and the rights and restrictions placed on the patient.
- Staff adhered to consent to treatment and capacity requirements. Copies of consent to treatment forms were attached to all relevant patients' medication cards.
- Staff explained patients their rights under the Mental Health Act. Staff completed this on a monthly basis. Staff had access to administrative support and legal advice on the implementation of the Mental Health Act from a central team within the organisation. Staff were aware of where to go to get advice, when needed. Staff completed detention paperwork correctly. This was up to date and stored appropriately.
- Staff completed regular audits to ensure the Mental Health Act was applied correctly. These audits had recently highlighted an error in which staff had not completed a patient's section renewal and the patient was being detained without the appropriate legal authority. Staff took appropriate action to rectify this situation. Staff informed the patient of the error and advised of their rights as an informal patient. The learning from this incident prompted the service to employ a Mental Health Act administrator.
- Patients had access to an independent mental health advocate. This provider used a local advocacy service to provide this support.

Good practice in applying the MCA

Good

Forensic inpatient/secure wards

- All staff had received training on the Mental Capacity Act. Staff we spoke to had a good understanding of the Mental Capacity Act. Staff were able to explain what action they would take if they suspected a patient lacked capacity.
- The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and how to refer to it if they required any guidance.
- Staff assessed capacity and capacity to consent appropriately. Staff told us that the doctor completed capacity assessments with another of member of staff. We reviewed patient records and saw evidence that staff had completed capacity assessments on a decision specific basis.
- Staff supported patients who lacked capacity to make decisions in their best interest. If a patient lacked capacity, staff arranged a best interest decision meeting. This included family and care coordinators or any other relevant person involved in the patient's care.
- Staff knew where to get advice regarding the Mental Capacity Act. Staff told us if they were unsure of anything they would speak to the nurse in charge, ward manager, a social worker or the hospital director.
- The provider had not made any deprivation of liberty safeguards applications within the past 12 months.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- Staff treated patients with compassion, dignity, and respect. We observed positive engagement between staff and patients. We observed positive relationships between staff and patients.
- Patients told us that staff were kind, caring and compassionate. We spoke to five patients who told us they had a good relationship with staff and staff treated them with dignity and respect.
- Staff demonstrated a good understanding of patients' needs. Staff were able to explain the needs of individual patients and how they met these needs. For example, how they met the religious needs of the patients by taking them to church, or supporting them to access the spiritual room. Staff also explained how they supported patients to pursue personal interests, such as supporting patients with photography and feeding the birds in the garden.

The involvement of people in the care they receive

- The admission process orientated patients to the ward and informed them of the service. Staff gave patients an admission pack that contained information about the service and the activities on offer. This also contained information on how to make complaints.
- We saw evidence in the care records that patients were involved in the planning of their care. Care plans had a section where patients could comment. Patients attended care review meetings where they could discuss their care plan and any changes they felt needed to be made. Patients told us that staff offered them a copy of their care plans.
- Patients had access to an advocacy service. The provider used a local advocacy service. The advocate attended the service on a weekly basis and came to support patients in care reviews and Mental Health Act tribunals.
- Families and carers were involved in patient care. We spoke to three carers. The provider actively engaged with families and carers, and held regular one-to-one sessions. Staff invited family and carers to attend care review meetings. Carers told us the provider had conference call facilities for families and carers who were unable to attend.
- Patients were able to give feedback on the service they received. The provider held regular community meetings in which patients provided input into service development. Each ward had a patient representative who attended meetings with management and put forward ideas for potential changes.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Good

Forensic inpatient/secure wards

- The provider had average bed occupancy over the six-month period between May 2017 and October 2017 was 95%. Westleigh Heights ward had bed occupancy of 100% and South Weald ward had a bed occupancy of 90%.
- The provider admitted nationally so there were no out of area placements.
- Patients had access to a bed upon return from long-term leave. The provider did not admit into beds whilst patients were away on leave.
- Patients were discharged at an appropriate time of day. During the discharge planning process, the provider liaised with families, carers, and future placement areas to arrange an appropriate discharge date and time that was appropriate for all involved.
- The provider did not have any patients whose discharge was delayed between May 2017 and October 2017. Any delays in discharge were due to clinical reasons.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had a full range of rooms and equipment to support treatment and care. These included a clinic room, therapy kitchen, the spiritual room, family visiting room, gym, and therapy rooms. The provider also had a room that was used as a shop run by the patients. The provider had a horticultural centre which patients attended as part of the therapeutic programme. Patients grew vegetables and produce which they cooked in the therapeutic kitchen, and sold to staff and visitors.
- The provider had quiet areas where patients could meet visitors. There was a visitors' lounge which was off the main ward area where patients met family and friends.
- Patients were able to make phone calls in private. Each ward had a telephone room where patients could make private phone calls.
- Patients had access to outdoor space. There was a secure garden in between the wards for patients to access. The provider also had extensive grounds that the patients were able to access if they had sufficient leave under the Mental Health Act.
- The food was of good quality. All the food was prepared on site each day. Patients we spoke to told us that the food was excellent and that there was always a choice if patients did not like what was on the daily menu. There was always an option to have something different, as the kitchen provided a secondary options menu.
- Patients had access to hot drinks and snacks throughout the day. There was a coffee machine and water fountain in the lounge of each ward. Patients could also purchase snacks from the shop on site.
- Patients were able to personalise their bedrooms. Patients were able to bring in personal items such as pictures, posters, and bedlinen to personalise their bedrooms.
- Patients had access to a wide range of activities. Activities were available seven days a week. Activities included cooking, maths, English, reading group, real work opportunities and horticulture. Staff also provided ward based activities such as games and films as well as community access.

Meeting the needs of all people who use the service

- The provider had made adjustments for people requiring disabled access. Both wards were on the ground floor and all doors were wide enough to allow for wheelchair access. There was a lift to enable disabled access to the first floor.
- The provider had accessible information available on treatments, local services, patient rights, and how to complain. The provider was able to access information in different languages when required.
- The provider had access to interpreter service. The provider had a patient who regularly used the interpreter service for their care reviews.
- The provider was able to offer food that met the dietary requirements of different religious and ethnic groups. We saw evidence on the menus that halal meat was available for a Muslim patient.
- The provider had access to spiritual support for patients. The provider had a spiritual room which contained various religious texts. There were also hand-washing facilities available. Staff were aware of the direction of Mecca. The provider supported one patient to attend a local church service.

Listening to and learning from concerns and complaints

- The provider had received two complaints within the last 12 months. The provider partially upheld one complaint. However, the provider did not uphold the second complaint.

Good

Forensic inpatient/secure wards

- Patients knew how to complain. Staff provided patients with information on how to make complaints within the admission pack. Patients we spoke to told us that they would be confident to make complaint and that staff would deal with this appropriately.
- Staff knew how to handle complaints appropriately. Staff we spoke to were able to explain what action they would take if a patient made a formal complaint to them. Staff explained who they would escalate the complaint to what action they would take.
- Staff received feedback on the outcomes of investigations into complaints. Staff told us they received feedback through handovers and team meetings. We reviewed the minutes of team meetings and saw that staff discussed the outcomes of complaints and any lessons learnt identified.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- Staff were aware of the organisations visions and values. Staff explained how they always put patients first and treated patients as though they were a part of the family. Staff told us they acted with integrity, and always strived for excellence within their work .We saw evidence of this throughout the inspection.
- Team objectives were based on the organisation's values and objectives. Staff told us the goals set as part of their annual appraisal reflected the organisations values and objectives.
- Staff were aware of who the senior managers in the organisation were. Staff told us that members of the senior management team had visited the wards several times over the past year. Staff told us that senior managers within the hospital were very approachable and available should they have any concerns.

Good governance

- The provider had systems in place to monitor staff compliance with mandatory training. The provider used an online dashboard which highlighted the percentage of staff that completed each mandatory training course. The dashboard also highlighted individual staffs' compliance with mandatory training. The provider had a plan to improve staff compliance with mandatory training so that they met the provider's target of 95%. We reviewed this plan and saw that it has been effective in increasing mandatory training compliance.
- The provider used dashboards to monitor staff compliance with supervision and appraisals. This dashboard highlighted when staff had recently had supervision and when the next supervision was due. This enabled the provider to respond effectively if staff were not compliant with the provider's policy on supervision.
- The provider ensured that shifts were covered with enough staff who had the right qualifications and experience. We reviewed the duty rotas. These showed that, where the provider was unable to fill shifts with regular staff, they were able to cover this with bank and agency staff. The provider used regular bank and agency staff to ensure continuity of care for the patients.
- Staff maximised their time on direct care activities. We saw evidence throughout the inspection that staff spent time on the ward engaging with patients rather than undertaking administrative tasks.
- Staff participated actively in clinical audits. Staff had responsibility for completing care plan and risk assessment audits. The managers tracked when audits had been completed and when they were due for renewal through the use of the dashboard.
- Staff received feedback from incidents and complaints. Managers shared learning from incidents and complaints through team meetings and handovers. Staff also received information from lessons learned from across the organisation through an email newsletter.
- The provider used key performance indicators to gauge the performance of the team. These included staff turnover, training, sickness, supervision, and medication. The provider was able to monitor progress towards meeting the key performance indicators with the online dashboard system.
- Managers had sufficient authority to perform their role. Managers told us that they felt they were well supported by senior managers with the decisions they made. There was appropriate administration support for managers. The provider was in the process of recruiting a ward clerk and the hospital manager had a personal assistant to support with administrative tasks.

- Staff had the ability to submit items to the provider's risk register. If staff identified a possible area of risk, they escalated this to the ward managers. Ward managers discussed risks with the hospital manager to determine whether to add the concern to the risk register.

Leadership, morale and staff engagement

- The provider had a sickness rate of 3.5%. The provider monitored staff sickness, and had systems in place to address any issues with staff sickness.
- The provider had not had any issues with bullying and harassment in the past 12 months.
- Staff knew how to use the whistleblowing policy. Staff told us that they felt confident in raising concerns without fear of victimisation. Staff told us they felt that if they raised issues with management, managers would take action, and they would deal with it appropriately.
- Senior staff told us staff morale had been quite low, although this was starting to improve. The provider monitored staff morale with a tool called the morale o'meter. The provider sent an email to all staff in which they rated their morale from one to 10. The current rating for the hospital was 5.6.
- Staff told us they worked well as a team, that there were good relationships and that the team were very supportive of each other.
- Staff were open and transparent and explained to patients when things went wrong. We reviewed the incident reports and saw evidence within care records that staff had discussed with patients when things went wrong, such as when staff had made medication errors.
- Staff were offered the opportunity to give feedback on services and input into service development. The provider held a forum where staff had the opportunity to provide feedback and make suggestions for service improvement to the executive team.

Commitment to quality improvement and innovation

- The provider had a healthcare divisional quality plan. This was a national plan they used to improve quality in areas such as staff development, care planning, observation engagement, and security across all their services.
- The provider participated in the Quality Network for Forensic Mental Health Services. Quality Network aims to facilitate quality improvement through supportive networking and peer review process.
- Staff at the service were involved in research projects looking into mindfulness and engagement. The research is looking at how mindfulness can help improve engagement with services.

Outstanding practice and areas for improvement

Outstanding practice

The horticultural group offered patients the chance to develop their skills and gave them the opportunity to have some work experience. The provider allocated facilities in the grounds where patients grew vegetables and flowers. Patients had developed this area including building a pagoda, designing, and creating the zen garden which is a quiet space for patients to use.

The service had won the Essex wildlife trust award, the living landscapes award. Patients also attended a work placement at Lambourne End, a local outdoor learning centre. This gave the patients the opportunity to use their horticulture skills and gain work experience.

Patients had access to 'shop and social', a shop in the hospital that patients ran. Patients attended the shop daily, purchased snacks, and other items, whilst socialising. Patients were responsible for managing stock, auditing and accounting. Patients we spoke to were very complimentary about both these activities and said that it gave them a sense of purpose and achievement and helped to develop their functional skills.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they identify all ligature risks and document all actions to mitigate identified risks within the ligature risk assessment.
- The provider must ensure that staff document all identified risks within patient's risk assessments and that risk assessments are updated following incidents.

Action the provider SHOULD take to improve

- The provider should ensure that staff complete all seclusion documentation appropriately.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not identified all ligature anchor points in the ligature risk assessment. The provider had not documented all actions staff should take to mitigate the risks of identified ligature points. • Staff had not documented all identified risks within the risk assessments. Risk assessments did not clearly identify when patients were subject to Multiagency Public Protection Arrangements. This was a breach of regulation 12 (2) (a) (b)