Humber NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

Willerby Hill
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV936	Willerby Hill	Darley House	HU10 6ED
RV936	Willerby Hill	Derwent Ward	HU10 6ED
RV936	Willerby Hill	Greentrees	HU10 6ED
RV936	Willerby Hill	Ouse ward	HU10 6ED
RV936	Willerby Hill	South West Lodge	HU10 6ED
RV936	Willerby Hill	Swale ward	HU10 6ED
RV936	Willerby Hill	Ulleswater ward	HU10 6ED

This report describes our judgement of the quality of care provided within this core service by Humber NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber NHS Foundation Trust.

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

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

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

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 4

Information about the service 6

Our inspection team 6

Why we carried out this inspection 6

How we carried out this inspection 7

Areas for improvement 7

Detailed findings from this inspection

Findings by our five questions 9

Action we have told the provider to take 16

Summary of findings

Overall summary

We found the following areas the trust needs to improve:

- The multi-disciplinary team did not always carry out reviews for patients in seclusion within the times specified in the Mental Health Act code of practice.
- Not all qualified staff were trained to provide immediate life support.
- Oxygen and a defibrillator located on Derwent ward was shared with Ouse ward. There was no risk assessment of the impact sharing this equipment could have on patients in an emergency.

However we found the following areas of good practice:

- The service had complied with several of the regulatory breaches identified in the warning notice.
- There were adequate stocks of emergency medicines on all wards. All medicines and equipment were within the expiration date and fit for use. Staff knew where emergency medicines and equipment were located.
- Staff carried out physical health monitoring following the use of rapid tranquilisation in line with trust guidance.
- Patient entering seclusion had individualised seclusion care records and exit plans. Staff recorded the justification for the use of seclusion.
- The service had decommissioned those seclusion rooms not fit for purpose.
- The trust had introduced a new policy, which ensured that patients' rights were protected and they were being treated in line with guidance. Staff were aware of new policies and acted in accordance with them.

Following this inspection, the CQC withdrew the warning notice and issued the trust with a requirement notice to address the outstanding issues identified.

Summary of findings

Are services safe?

We found the following issues that the trust needs to improve:

- Staff did not always carry out seclusion reviews within recommended time scales.
- Several staff had still not received training in immediate life support.
- There was no risk assessment of the impact sharing emergency equipment between Ouse ward and Derwent ward could have on patients in an emergency.

However, we found the following areas of good practice:

- There were adequate stocks of emergency medicines on all wards and these were within their expiration date.
- Staff carried out physical health monitoring for patients who received rapid tranquilisation.
- Staff completed seclusion records and exit plans for patients who used seclusion.
- Policies relating to rapid tranquilisation and use of seclusion were up to date.
- Staff followed new policies introduced by the trust, which ensured patients' rights were protected.

Are services effective?

We did not assess this domain during this inspection

Are services caring?

We did not assess this domain during this inspection

Are services responsive to people's needs?

We did not assess this domain during this inspection

Are services well-led?

We did not assess this domain during this inspection

Summary of findings

Information about the service

Humber NHS Foundation Trust provides mental health services for people across East Yorkshire. This includes forensic inpatient/secure wards. There are seven inpatient facilities based at the Humber Centre for Forensic Psychiatry, which is a purpose built hospital at Willerby Hill in Hull. The service is registered to care for patients detained under the Mental Health Act 1983. The Humber Centre provides medium and low secure care for mentally disordered or learning disabled male offenders, and men with a personality disorder who require assessment, treatment and rehabilitation within a secure environment.

- Derwent ward provides care for up to 10 male patients with complex mental health problems, who require high levels of support, assessment and intervention.
- Ouse ward provides care for up to 14 male patients who require less intensive support than those on Derwent ward. Staff focus on working with patients to enable them to move on to the next stage of their care.
- Swale ward provides care for up to 15 adult male patients with personality disorders, which are linked to their offending and risk behaviours.
- Ullswater ward provides care and treatment for up to 12 male patients with a learning disability and a diagnosed mental disorder.
- Greentrees ward provides medium secure facilities for up to 16 male patients who are considered a risk to others.
- Darley House ward supports up to eight male patients who have not made the anticipated progress within traditional low secure services and may have been involved with services for a number of years.
- South West Lodge is a secure community preparation unit and accommodates up to four patients. It provides individually graded levels of independence, supervision and security.

In April 2016, the CQC carried out a comprehensive inspection of the trust and rated the trust overall as 'requires improvement'. We rated the forensic inpatient/secure wards as 'inadequate' overall. The CQC issued a section 29A warning notice for the trust to make significant improvements. These related to regulation12 and regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust sent the CQC an action plan for addressing the warning notice, including an update of the progress of actions taken. As of 10 October 2016 the trust had completed all actions in their plan and were monitoring and auditing compliance with regulations. They appointed a rapid interventions team to support and assist adult mental health teams across the trust in changing working practice and culture.

The trust appointed a new interim chief executive officer in September 2016, who had a mental health background. In addition, they appointed two non-executive board members with mental health backgrounds.

Our inspection team

The lead inspector for this service was Jacqui Holmes. The team that inspected this core service comprised three Care Quality Commission inspectors (mental health) and one Care Quality Commission inspector (pharmacy).

Why we carried out this inspection

We last inspected this core service in April 2016 as part of a comprehensive inspection of Humber NHS Foundation

Summary of findings

Trust. We rated forensic inpatient/secure services as inadequate overall. The safe and effective domains as inadequate, caring as good and the responsive and well-led domains as requires improvement.

We found that significant improvements were required and issued the trust with a warning notice under section 29A of the Health and Social Care Act 2008. We carried out an unannounced focused inspection to find out if the trust had complied with the regulatory breaches identified in the warning notice.

The warning notice told the provider that it must take action to improve the forensic inpatient/secure wards in relation to the following concerns:

- effective governance arrangements were not in place in respect of the use of rapid tranquilisation and on occasions rapid tranquilisation was used inappropriately by staff
- effective processes and procedures were not in place to provide systematic assurance that there was not inappropriate use of seclusion and that safe care was being delivered whilst patients were in seclusion
- there was a blanket policy of monitoring patient mail within the forensic services. There was an ineffective governance arrangement in place to oversee the monitoring of patients mail in the forensic services.

The concerns relating to rapid tranquilisation and the use of seclusion were breaches of regulation 12(2) (a) (b) (c) (d),(e),(f) and (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014, safe care and treatment.

The blanket policy of monitoring patient mail was a breach of regulation 13 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment.

How we carried out this inspection

The focus of this inspection was to establish what actions the trust had taken to address and resolve the regulatory breaches identified in the warning notice under section 29A of the Health and Social Care Act 2008. These regulatory breaches occurred in the safe domain. It was not the purpose of this inspection to re-consider the rating.

Before visiting, we reviewed a range of information we hold about the core service. We carried out an unannounced visit on 1 and 2 December 2016.

During the inspection visit, the inspection team:

- visited six wards at the Willerby Hill site
- spoke with 14 staff
- attended and observed four hand-over meetings and three multi-disciplinary meetings
- reviewed 18 seclusion records
- reviewed staff training figures for immediate life support
- looked at policies, procedures and other documents, which related to the running of the service.

Following the inspection, we sought assurance from the trust about their commitment to comply with the warning notice. The trust responded with detailed and candid analysis of their current position, and ongoing actions to achieve compliance with regulatory breaches.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all qualified staff are up to date with immediate life support training.
- The provider must ensure that clinicians carry out the necessary reviews for those patients in seclusion within the time frames specified in their policy.

Action the provider SHOULD take to improve

- The trust should review how quickly staff on Ouse ward are able to access the emergency equipment on Derwent ward and the impact this would have on a patient requiring resuscitation or oxygen.

Humber NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Darley House	Willerby Hill
Derwent ward	Willerby Hill
Greentrees	Willerby Hill
Ouse ward	Willerby Hill
South West Lodge	Willerby Hill
Swale ward	Willerby Hill
Ullswater ward	Willerby Hill

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

The trust had seven forensic inpatient wards, five of which were located within the Humber Centre. Greentrees Ward and South West Lodge were located on the same site, though in separate buildings a short distance away.

At our last inspection, we found that the provision of emergency medicines was variable and did not meet the essential stock requirements set out in the trust's resuscitation policy, including medicines that should be immediately available when rapid tranquilisation is used. Three of the forensic wards we visited did not meet this requirement. Rapid tranquilisation happens when qualified staff give medicines by injection to a person displaying aggressive or agitated behaviour to help quickly calm them. The trust had a rapid tranquilisation policy, which was due for review in February 2016. They had not reviewed it at the time of our inspection in April 2016. Trusts must review their policies regularly to ensure they are current and take into account most relevant guidance. We also found that staff on Greentrees Ward were not aware of the location of the emergency equipment.

During this inspection, we were provided with an updated resuscitation policy, which the trust had put in place in September 2016. We reviewed the new policy and found it was in accordance with national guidance.

We checked the provision of emergency medicines and found adequate stocks were available in line with the essential stock requirements set out in the updated policy. However, the acting deputy charge nurse on Ouse Ward told us that oxygen and a defibrillator were not available on Ouse ward; the ward shared this equipment with Derwent ward next door. The charge nurse was not aware of any practice drills or risk assessment carried out to assess the impact of sharing this equipment. For example, how long it would take staff on Ouse ward to access the defibrillator on Derwent ward and bring it to Ouse ward for use on a patient who required resuscitation.

Records showed staff carried out regular documented checks to ensure medicines and equipment were fit for use, apart from on Derwent Ward were there were some gaps in the records. We interviewed four staff on Greentrees Ward and found all were aware of the location of the emergency medications. This showed the service was no longer in breach of regulation 12 (2) (e) (f) and (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014 and complied with this requirement of the warning notice.

Safe staffing

At our last inspection, we found that not all qualified staff had received training in immediate life support. The National Institute for Health and Care Excellence guidance [Violence and aggression: short-term management in mental health, health and community settings, NG10.May 2015] states that staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend in an emergency if restrictive interventions might be used. It is important that all qualified staff have this training so they know what action to take should a patient have an adverse effect from rapid tranquilisation, including the use of emergency medication.

We reviewed the numbers of staff trained in immediate life support during this inspection. The trust had appointed a resuscitation officer and rolled out additional training in immediate life support to staff not yet trained. We found an improvement in the number of staff trained in immediate life support although figures across some wards were still low. Figures provided by the trust were:

- Greentrees – Seven of 12 staff trained which is 58%
- Darley Ward – Six of eight staff trained which is 75%
- Derwent Ward – Eight of nine staff trained which is 89%
- Ouse Ward – Six of 10 staff trained which is 60%
- Ullswater Ward and Swale Ward – 100% of staff trained.

Information provided by the trust showed that those who had not completed their training were booked onto training sessions. All staff should have received appropriate training by 31 March 2017.

Assessing and managing risk to patients and staff

At our last inspection in April 2016, we found staff did not have a clear understanding of what constitutes rapid tranquilisation and as a result, the required physical checks

and observations of patients were not being carried out in accordance with the trust's policy. The trust policy itself was overdue a review, having been scheduled for February 2016.

During this inspection, we checked to see what improvements the trust had made. The trust had updated their rapid tranquilisation policy in September 2016. This set out the monitoring that staff must carry out following the use of rapid tranquilisation. The policy was in accordance with national guidance [Violence and aggression: short-term management in mental health, health and community settings, NICE guideline, NG10.May 2015]. The trust policy also stated this monitoring applied to when any 'when required' medicine was given by injection to calm a patient.

We checked patient records and reviewed three episodes where staff had administered medicines by injection. In all three episodes, staff had carried out the appropriate physical health monitoring as set out in the trust policy. This showed the service was no longer in breach of regulation 12 (2) (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014 and complied with this requirement of the warning notice.

At our last inspection, the forensic inpatient and secure services had six seclusion rooms. These were located on Derwent Ward, Ullswater Ward, Swale Ward and Greentrees. We found the seclusion rooms on Swale and Ullswater wards met the standards required by the Mental Health Act code of practice. However, the seclusion rooms on Derwent Ward and Greentrees were in need of cleaning and not fit for purpose as required by chapter 26 of the Mental Health code of practice 2015.

During this inspection, we found that the trust had de-commissioned the seclusion rooms on Derwent Ward and Greentrees. The remaining seclusion rooms were clean and tidy and fit for purpose. This showed the service was no longer in breach of regulation 12 (2) (d) of the Health and Social Care Act (Regulated Activities) Regulations 2014 and complied with this requirement of the warning notice.

At our last inspection, we found seclusion records did not meet the Mental Health Act code of practice minimum requirements. The code of practice states that 'A seclusion care plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible.' Eight seclusions records we viewed indicated that doctors did not attend within the required timeframes. 'All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped (The Mental Health Act code of practice 26.126).' In all records reviewed on the forensic wards, it was difficult to locate patient's seclusion contemporaneous notes.

During this inspection, we reviewed 18 seclusion records and found that there had been an overall improvement in the quality of seclusion care plans. Staff recorded the reason for patients being placed in seclusion and the steps they needed to take in order to end seclusion. We found the provider had put audits in place to assess the quality of seclusion records, with the matron from the Humber Centre reviewing seclusion records monthly. Information supplied by the trust showed that although staff were receiving additional training in the use of seclusion and the MHA code of practice, not all staff had applied it to their practice.

We found, there were continued delays in clinicians carrying out the necessary patient reviews:

- five medical reviews were more than one hour late
- one nursing review was carried out an hour late
- a multidisciplinary review was more than five hours late.

The trust set up a rapid intervention team in October 2016, whose aim was to provide staff with coaching and support in dealing with episodes of seclusion appropriately.

This meant there was an ongoing breach of regulation 12 (2) (a) and (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Our previous inspection showed that patients on all forensic wards had to open their post in front of staff. If a patient refused to open their mail, they would withhold the patient's mail. This was a blanket restriction and was not supported by the powers given under section 134 of the Mental Health Act 1983, which states that high security psychiatric hospitals can withhold mail in certain circumstances. We identified this restrictive practice during the 2014 inspection; however, the trust had failed to make changes following the earlier inspection.

During this inspection, we found that the trust had introduced a new policy for the management of patients' mail. The policy, 'Patients Correspondence (managing

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

incoming mail and withholding outgoing mail and associated risks', was introduced in June 2016 and identified how the practice of withholding mail was a breach of The Human Rights Act. The policy gave staff clear guidelines on steps they should take to balance patient rights and the potential risks involved.

We spoke with 14 staff members over the seven wards. All the staff we spoke with told us about the new policy and confirmed that there had been changes on wards. Staff told us that patients were risk assessed to see if they posed a risk to themselves or others by having unrestricted access to mail.

We found three patients who were asked to open their mail in the presence of staff. We reviewed these patients' care records, associated risk management plans, and found the plans were personalised and individual to the patient. There was valid justification for the continued monitoring of their post. This showed the service complied with the requirement of the warning notice in relation to this blanket restriction and were no longer in breach of regulation 13 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Track record on safety

We did not assess this domain during this inspection

Reporting incidents and learning from when things go wrong

We did not assess this domain during this inspection

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

At the last inspection in April 2016 we rated effective as **inadequate.** It was not the purpose of this inspection to re-consider the rating.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

At the last inspection in April 2016 we rated caring as **good.** It was not the purpose of this inspection to re-consider the rating.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

At the last inspection in April 2016 we rated responsive as **requires improvement.** It was not the purpose of this inspection to re-consider the rating.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

At the last inspection in April 2016 we rated well-led as **requires improvement.** It was not the purpose of this inspection to re-consider the rating.

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 How the regulation was not being met: On Greentrees ward and Ouse ward, not all qualified staff were trained in immediate life support. On Derwent ward and Darley ward, staff did not always carry out seclusion reviews within recommended time scales. This was a breach of regulation 12 (2) (a) (b) (c)