St Andrew's Healthcare - Nottinghamshire

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Inadequate
Are services responsive?	Good
Are services well-led?	Inadequate

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.

Summary of findings

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

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker
Chief Inspector of Hospitals

Overall summary

We rated St Andrew's Healthcare Nottinghamshire as inadequate because:

- Staff did not protect patients from avoidable harm or abuse. Managers did not ensure care environments were safe. Our inspectors identified potential ligature anchor points on Newstead ward that were not included in the ward ligature risk assessment. Also, the ligature risk assessments that were available to staff on Thoresby ward were out of date. There was a blind spot and a scratched viewing lens in the en suite areas of seclusion rooms. Staff on Wollaton ward did not adhere to infection control principles.
- Patient's privacy and dignity were not always respected. Patient's basic needs were not always met. Staff searched a patient in a communal area in front of peers. Staff were not responding to patients' requests when they were in seclusion. This included requests to go to the toilet, to use the shower, for food, medicines and for blankets. This resulted in distress and embarrassment for patients. Staff used inappropriate and disrespectful language in a patient's record. Patients told us on some wards that staff ignored them, took a punitive approach and spoke to them in a disrespectful way.
- Staff did not adhere to the Mental Health Act Code of Practice when using seclusion. There were gaps in seclusion reviews, staff did not end seclusion at the earliest opportunity or complete observations correctly. Staff permitted patients on Thoresby ward to vote on whether to end or continue with other patients' seclusion. Senior managers told us that this was normal practice as part of the therapeutic community model. This was not acceptable practice.
- Staff did not seek the consent of patients to have other patients involved in decision making about their general care on Thoresby ward (a therapeutic community). In ten out of 24 records staff had not recorded that they had considered a patient's mental capacity to understand and consent to treatment.
- Leaders and governance arrangements had not assured the delivery of high quality care. Managers had not ensured that all staff worked within the legal frameworks of the Mental Health Act and Mental Capacity Act. Quality audits had not identified the use of inappropriate and disrespectful language in a patient's record. Leaders had not ensured services worked towards recognised standards. Thoresby ward did not meet the service standards required to be accredited by the Royal college of Psychiatrists for therapeutic communities.

However:

- Staff were assessing and managing risks for individuals. We examined 24 patient records, all showed that staff undertook a risk assessment of every patient on admission and updated this regularly and

Summary of findings

after every incident. More than 90% of staff had completed safeguarding training and demonstrated understanding of how to assess safeguarding risks and make appropriate referrals.

- The provider employed the full range of disciplines needed to deliver care. This included autism specialists, nurses, occupational therapists, psychologists, social workers, healthcare assistants and activities coordinators. Staff ensured that patients had access to advocacy services for support.
- Patients told us that some staff were friendly and approachable and supported them to progress in their treatment. Patients told us that staff involved them in planning their care and assessing their risks. Staff recorded patient involvement in records.

Summary of findings

Contents

Inadequate

St Andrew's Healthcare Nottinghamshire

Services we looked at
Forensic inpatient/secure wards

Summary of this inspection

Background to St Andrew's Healthcare - Nottinghamshire

St Andrew's Healthcare Nottinghamshire is a 66 bedded independent hospital for men detained under the Mental Health Act. Patients admitted include those with a diagnosis of autism and Asperger's syndrome; and have either established or suspected borderline learning disabilities. They may also have additional mental health needs, and a history of offending or challenging behaviour. The service accepts referrals from across the United Kingdom. The hospital consists of four wards:

Newstead ward is a 16 bedded low secure ward for men who have a primary diagnosis of autistic spectrum disorder.

Wollaton Ward is a 17 bed medium secure ward for males with autistic spectrum disorder.

Thoresby ward, operating as a therapeutic community, is a 14 bed medium secure ward for men with mild or borderline learning disability. Patients may also have mental health needs and/ or a history of offending or challenging behaviour.

Rufford ward is an 18 bed low secure ward for men with autistic spectrum disorder or learning disability.

St Andrew's Healthcare Nottinghamshire is registered with CQC to provide treatment of disease, disorder or injury and assessment or medical treatment for persons detained under the Mental Health Act 1983.

This service was last inspected on 26th September 2017, this was a focused inspection carried out in response to concerns raised about the service. We did not rate the service at this inspection. We found the following breaches of regulation 12, safe care and treatment;

- Seclusion records were not adequately documented to show that patients received medical reviews in line with the provider's policy.
- Not all ligature risks were identified, assessed and mitigated against.
- Maintenance of equipment and estates was not conducted in a timely manner.
- The incidents of restraint and prone restraint had increased since the last report.

A comprehensive inspection was carried out in June 2015 when the service was rated as good across all key questions.

We found that the provider had addressed some, but not all of the issues from the last inspection. The issues that remain are identified later in this report.

Our inspection team

The team that inspected the service comprised one CQC inspection manager, five CQC inspectors including a pharmacy inspector, one CQC Mental Health Act reviewer, one assistant inspector, two specialist advisors including an occupational therapist and a doctor, and one expert by experience.

Why we carried out this inspection

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

Summary of this inspection

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 all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 25 patients who were using the service;
- spoke with three carers;
- spoke with the registered manager and managers, or acting managers for each of the wards;
- spoke with 35 other staff members; including doctors, nurses, autism specialists, occupational therapists, psychologists, healthcare assistants, social workers and cleaning staff;
- attended and observed one care activity and two multi-disciplinary meetings;
- looked at 24 care and treatment records of patients and 16 seclusion records;
- carried out a specific check of the medication management on all wards;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 25 patients. Whilst some patients told us that some staff were punitive, disrespectful and breached confidentiality, others told us that staff were friendly, approachable, caring and kind.

A number of patients told us that there were not enough staff to facilitate leave and access to activities and there was high use of bank and agency staff. Patients also told us that staff often cancelled occupational therapy sessions at short notice.

Two patients reported issues with their shower and light not working. We passed these issues onto the provider and they were rectified during the inspection.

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?

Inadequate

We rated safe as inadequate because:

- Staff did not protect patients from avoidable harm or abuse. Managers had not ensured safe care environments. Our inspectors identified potential ligature anchor points on Newstead ward that were not included in the ward ligature risk assessment. Also, the ligature risk assessments that were available to staff on Thoresby ward were out of date. The provider's management of aggression training did not equip staff to intervene safely for all patients.
- Staff were not compliant with the Mental Health Act Code of Practice, with respect to the use of seclusion. Staff permitted patients on Thoresby ward to vote on whether to end other patients' seclusion. Senior managers told us that this was normal practice as part of the therapeutic community model. Staff were keeping patients in seclusion for longer than required. In five out of 16 records, staff had stated in the 15-minute observation checks that the patient was settled and calm but staff had not terminated the seclusion at the earliest opportunity. Doctors and nurses were not completing reviews as required in five out of 16 records reviewed. Staff were not completing observations required in three out of 16 records reviewed. Staff had not completed seclusion care plans in six out of 16 records. Seclusion rooms did not meet the standards in the Mental Health Act Code of Practice. We identified a blind spot and a scratched viewing lens in the en suite areas of Newstead and Rufford seclusion rooms. However, the provider rectified the blind spot and viewing lens issues during the inspection.
- Staff did not always adhere to infection control principles. On Wollaton ward, we saw takeaway boxes disposed of in a clinical waste bag; staff had incorrectly put general laundry and a mop head in a contaminated waste bag; contaminated laundry had not been put in a contaminated waste bag and had been left in an untied bag.

However:

- Staff were assessing and managing risks for individuals. We examined 24 patient records, all showed that staff undertook a risk assessment of every patient on admission and updated this regularly and after every incident.

Summary of this inspection

- Ninety three percent of staff completed safeguarding training and made safeguarding alerts when appropriate. The service worked closely with the local authority safeguarding team and multi-agency safeguarding hub.
- Managers shared learning from incidents. Managers held daily morning meetings to discuss any serious incidents from overnight or the previous day. Managers shared actions from these meetings with staff via email and in team meeting minutes.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not always receive specialist training. Managers had not ensured staff on Thoresby ward had completed training in therapeutic communities. According to data from the provider only four staff on Thoresby ward had completed this training. The Royal College of Psychiatrists' service standards for therapeutic communities' states that "all staff receive training in therapeutic communities for a minimum of two days per year".
- Staff did not always adhere to the Mental Capacity Act. We reviewed 24 patient records and staff had not demonstrated that they had assessed capacity in ten records, where appropriate, to patients' consent to treatment. There was no evidence that patients on Thoresby ward had consented to undergo the therapeutic community model of treatment, or that staff were considering mental capacity assessments to ensure that patients were able to understand the model of treatment to give their consent. A therapeutic community is a group-based form of therapy for people with mental health problems.

However:

- Staff assessed patients' needs and planned their care. We examined 24 care records, all were holistic and person centred. Staff had completed comprehensive and timely assessments of mental and physical health for each patient after admission and updated these regularly. There was ongoing monitoring of physical health problems.
- The provider had the full range of disciplines needed to deliver care. This included autism specialists, nurses, occupational therapists, clinical psychologists, social workers, healthcare assistants and activities coordinators.

Are services caring?

Inadequate

We rated caring as inadequate because:

Summary of this inspection

- Staff did not always treat patients with kindness or respect when providing care and treatment or during other interactions. We observed a patient being 'pat down' searched in front of other patients in the communal area on Thoresby ward. This was not in line with the provider's search policy. We reviewed 16 records of patients in seclusion. Staff were not responding to patients' requests in four records reviewed. This included requests to go to the toilet, to use the shower, for food, medicines and for blankets. In one record, the patient had requested to use the toilet at 21:45. The patient repeated this request three times and at 22:30 soiled themselves. The staff records of this incident were disrespectful and used inappropriate language. A patient told us that they had witnessed a member of staff ignoring a request from a patient in seclusion for a drink.
- Patients on Wollaton ward told us that staff were sometimes punitive in their approach, would ignore them if they were settled, could be disrespectful and had breached confidentiality at times. On Thoresby ward, we observed a senior staff member ignore a patient, who called out to them three times.

However:

- Patients told us that some staff were friendly, approachable, caring, nice, helped them to progress, were good listeners, supportive and patient focused.
- Patients told us they were actively involved in care planning and risk assessment and this was evident in care plans.

Are services responsive?

Good

We rated responsive as good because:

- The provider ensured that facilities promoted recovery and dignity. Patients had their own bedroom with en suite facilities. The provider supported patients to personalise their bedrooms on all wards. Staff had individually risk assessed this to allow patients access to technology such as games consoles in their rooms.
- The provider had a full range of rooms and equipment to support treatment and care and help patients build skills to support them when they moved on from services. The provider had a range of activity and therapy rooms, including a music room, information technology suite, therapy kitchens, gyms and arts and crafts rooms.

Summary of this inspection

- The provider had a RACE (race, culture and ethnicity) group who looked at ways that patients from different ethnic backgrounds could be supported, for example, providing different meals from around the world.
- The provider actively reviewed complaints and involved patients and staff in how they were resolved and responded to.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- Leaders and governance arrangements had not assured the delivery of high quality care. The provider's governance processes had not ensured that staff followed best practice in the care and treatment of patients. Managers had not ensured that all staff worked within the legal frameworks of the Mental Health Act and Mental Capacity Act. Quality audits had not identified all issues within the service. We identified staff practices in breach of both the Mental Health Act and the Mental Capacity Act and use of inappropriate language in one patient's care record.
- Leaders did not ensure that services worked towards recognised standards. Thoresby ward did not meet the service standards required to be accredited by the Royal college of Psychiatrists for therapeutic communities. The standards state that "the therapeutic community provides information to new patients and staff that describes the expectations of membership…and can demonstrate that all new staff and patients understand and accept the expectation as a condition of membership, for example, a signed contract." Thoresby ward was not meeting these standards.

However:

- Staff knew and agreed with the organisation's vision: to transform lives together. Managers ensured team objectives reflected the organisation's vision and values. Managers displayed their wards values on the walls in patient areas.
- Staff told us they knew how to use whistleblowing process and felt able to raise concerns without fear of victimisation.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- The provider had a dedicated centralised Mental Health Act team including an administrator who examined Mental Health Act (1983) papers on admission. Staff knew who the administrators were and could get support to ensure that they followed the act in relation to, for example, renewals, consent to treatment and appeals against detention.
- Staff kept clear records of leave granted to patients. Patients, staff and carers were aware of the parameters of leave granted, including risk and contingency/crisis measures.
- The provider had developed a combined mandatory training module on The Mental Health Act (1983), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards, 92% of staff had had completed this training.
- Staff adhered to consent to treatment and capacity requirements and had attached copies of consent to treatment forms to medication charts, where applicable.
- Staff explained patients' rights under the Mental Health Act on admission and routinely thereafter.
- Staff completed detention paperwork correctly and ensured that it was up to date and stored appropriately.
- Staff carried out regular audits to ensure that they were applying the Mental Health Act correctly and there was evidence of learning from these audits.
- Managers ensured patients had access to Independent Mental Health Advocate services. Staff were clear on how to access the advocacy service to support patients. Staff displayed posters with the names and contact details of the mental health advocacy services.

However:

- Staff did not always comply with the Mental Health Act Code of Practice for patients in seclusion. Staff did not always complete the required reviews and observations. We reviewed records that indicated staff were keeping patients in seclusion for longer than required. On Thoresby ward, which functioned as a therapeutic community, patients voted to on whether other patients should remain in seclusion.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not always adhere to the Mental Capacity Act. We reviewed 24 patient records and ten did not demonstrate that staff had considered capacity. We did not see evidence that the staff on Thoresby ward had explained to patients before admission what rules and expectations applied in a therapeutic community. We also saw no evidence that staff had assessed whether patients had the mental capacity to consent to this mode of treatment.
- The provider had a policy on the Mental Capacity Act (2005) including Deprivation of Liberty Safeguards which staff are aware of and can refer to on the intranet.
- Staff knew where to get advice regarding Mental Capacity Act, including Deprivation of Liberty safeguards. At the time of inspection all patients in the hospital were detained under the Mental Health Act (1983) so no Deprivation of Liberty safeguarding applications had been made.

Inadequate

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Inadequate

Safe and clean environment

- Managers had not ensured safe care environments. Managers had completed ligature assessments, but had not identified all ligature point risks. We found the telephone cord on Newstead ward had not been included on the ligature audit or risk assessment. Managers had not ensured an updated ligature audit and assessment was available to staff on Thoresby ward. However, they provided a copy of an up to date ligature audit following the inspection. A ligature point is a fixed point which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. We raised this with the provider who advised they would rectify this immediately. We spoke with two agency staff on Rufford ward, they were not aware of where the ligature cutters were located. We raised this with the provider, who took immediate action. This included updating the staff induction form and circulating a provider wide email to share the amended form for other services to use.
- The layout of all wards allowed staff to observe all parts of the wards.
- Each ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, we found three out of date items of equipment in the emergency bag on Newstead ward, staff had ordered replacements. The provider disposed of the out of date items.
- Seclusion rooms were not safe. Each ward had a seclusion room. We looked at all four seclusion rooms. Three of the seclusion rooms were out of action, due to damage caused by patients whilst in seclusion. The seclusion rooms did not meet the Mental Health Act Code of Practice. We identified a blind spot in the en-suite area of Rufford seclusion room and a scratched viewing lens in the en-suite area on Newstead ward. We raised this with the provider who rectified both issues during the inspection.
- Most ward areas were clean, had good furnishings and were well-maintained. However, on Newstead ward, in the sensory room we saw that the bubble machine had mould growing inside it.
- Staff did not always adhere to infection control principles. On Wollaton ward, we saw takeaway boxes disposed of in a clinical waste bag; staff had incorrectly put general laundry and a mop head in a contaminated waste bag; contaminated laundry had not been put in a contaminated waste bag and had been left in an untied bag. There were posters displayed in the sluice room with clear instructions for staff to follow regarding the management of laundry and waste.
- Staff ensured that equipment was well maintained and clean. We saw that clean stickers were visible and in date.
- Patients did not have alarms in their bedrooms. Throughout the hospital staff and visitors had access to appropriate alarms.

Safe staffing

- Staffing levels were safe on the days we inspected. The provider had invested in a dedicated workforce planning team using a recognised safer staffing tool. This work had started in August 2017. All wards had been assessed at level one to define and confirm safe

staffing numbers, optimum staffing numbers and ward establishment numbers. The planning team had also assessed the numbers of therapy staff required in the multidisciplinary team.

- From 01 May 2018 to 31 July 2018 the provider covered 1,536 shifts with bank staff from its own bureau, 910 shifts from agency staff and 353 shifts were unfilled across forensic secure wards.
- The wards that used highest numbers of bank and agency staff were Thoresby and Newstead wards. Thoresby had used bank staff to cover 592 shifts and agency staff to cover 276 shifts and had 79 unfulfilled shifts from 01 May 2018 to 31 July 2018. Newstead ward had used bank staff to cover 328 shifts and agency staff to cover 339 shifts and had 49 unfulfilled shifts over the same period.
- The provider had establishment levels of 30 whole time equivalent registered and 89 whole time equivalent unregistered staff across forensic secure wards as of 31 July 2018. There were 9.6 whole time equivalent vacancies for registered staff: four of these were for Thoresby ward, four on Wollaton ward, 1.28 on Newstead ward and 0.28 on Rufford ward. The provider had 2.52 whole time equivalent vacancies for unregistered staff across forensic secure wards. Rufford ward had vacancies for 5.54 whole time equivalent health care assistants, Thoresby ward had vacancies for 5.28 whole time equivalent healthcare assistants and Newstead and Wollaton wards had overstaffed healthcare assistant posts by 6.15 and 2.15 whole time equivalent posts respectively.
- Ward managers could adjust staffing levels daily to take account of case mix. Managers met each morning with the senior management team to discuss daily risk issues for their wards and adjusted staffing levels where necessary.
- During the inspection we observed that a qualified nurse was always present in communal areas of the ward.
- We saw in care records that there were enough staff so that patients could have regular 1:1 time with their named nurse.
- A dedicated physical healthcare team consisting of a non-medical prescriber, a paramedic and healthcare assistants ensured physical healthcare interventions were carried out safely.
- Doctors provided adequate medical cover day and night and could attend the ward quickly in an emergency.
- Managers ensured staff had received and were up to date with appropriate mandatory training and the mandatory training rate for staff was 92%.

Assessing and managing risk to patients and staff

- Ward practice meant that patients seclusion was not ended at the earliest opportunity as recommended by the Mental Health Act Code of Practice. Patients voting to end other patients' seclusion introduced a significant risk that people would be held in seclusion longer than required. On Thoresby ward, a patient's peers had voted to keep him in seclusion. The provider told us that this was the usual practice on the ward. This was a breach of the Mental Health Act Code of Practice, which states "seclusion should immediately end when a multi-disciplinary team review, a medical review or the independent multi-disciplinary team review determines it is no longer warranted. Alternatively, where the professional in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the patient's responsible clinician or duty doctor.…it (seclusion) should not form part of a treatment programme." The code further states that only the following persons can authorise seclusion; a psychiatrist, an approved clinician who is not a doctor or the professional in charge (for example, a nurse) of the ward. We were not assured that patients were being kept in seclusion for the shortest time necessary. In five out of 16 records staff had stated in the 15-minute observation checks that the patient was settled and calm but staff had not terminated seclusion at the earliest opportunity and in one case seclusion had continued for three days. Staff were not compliant with the Mental Health Act Code of Practice. Doctors had not completed a review of the patient within the first hour of seclusion in five out of 16 records. Staff had not completed observations every 15 minutes in three out of 16 records. Nurses had not completed nursing reviews every two hours in three out of 16 records. There had been no independent multidisciplinary review in three out of 16 records, where patients required this. Staff had not completed seclusion care plans in five out of 16 records. Staff had locked the toilet facilities in eight out of 16 records checked, with no written explanation as to why this was necessary. The provider advised that the rationale would be recorded in the patient's historical clinical risk-20. We checked these documents and found no evidence of this.

Inadequate

Forensic inpatient/secure wards

- Staff undertook a risk assessment of every patient on admission and updated this regularly and after every incident. We reviewed 24 patient records, which confirmed this.
- Staff used the short-term assessment of risk and treatability screening tool, and the historical clinical risk management -20 tool, both tools are nationally recognised risk assessment tools. Staff also used the risk for sexual violence protocol, where appropriate.
- We saw that good policies and procedures for observation were in place, including to minimise risk from ligature points and for searching patients and their bedrooms.
- Staff applied blanket restrictions on patients' freedom, only when justified. These were in line with restrictions required for secure services, for example, patients were only allowed mobile phones without internet access.
- Staff adhered to best practice when implementing a smoke free policy.
- All patients at this service were detained under the Mental Health Act.
- Staff told us that they only used restraint after de-escalation had failed and using correct techniques. Nearly all permanent and regular bank staff were trained in the management of actual or potential aggression. Staff had raised concerns with the provider that the management of actual or potential aggression training did not allow them to transfer two patients, if these patients were resistive. Staff had called the police to provide support in these situations. The provider told us they were in discussions with the training provider to create a bespoke training package to enable staff to meet the needs of this small group of patients.
- There were 94 episodes of seclusion across forensic secure wards between 01 February 2018 and 31 July 2018. These were highest on Wollaton ward with 25 seclusions.
- The provider told us they were focused on reducing restrictive practice and had implemented the 'safewards' model on Rufford ward. This model aims to reduce conflict and containment on mental health wards. On Rufford ward, 93 out of 142 incidents over the six months before the inspection were managed without using physical interventions. However, from 01 February 2018 to 31 July 2018 there were 220 episodes of restraint. This was an increase since our previous inspection when there had been 355 episodes of restraint over twelve months. These were highest on Wollaton ward with 126 restraints for 11 different patients. Over the same period there were 12 episodes of prone (face down) restraint. This was a decrease from the previous inspection, when the provider reported 40 episodes of prone restraint over twelve months. These were highest on Wollaton ward with six episodes of prone restraint.
- The provider reported zero use of rapid tranquilisation from 01 February 2018 to 31 July 2018.
- Ninety three percent of staff were trained in safeguarding and staff made safeguarding alerts when appropriate. The service worked closely with the local authority safeguarding team and multi-agency safeguarding hub.
- There was a visitor's room located off the wards for children visiting the service.
- Staff stored all information needed to deliver care securely and it was available to staff when they needed it, in an accessible form; including when people moved between teams. Staff accessed the majority of patient information on the providers electronic records system. Staff, including bank and agency, had access to this system. Staff kept paper copies of patient positive behaviour support plans on the wards, to enable easy access to them.
- Staff usually followed good practice in medicines management, with support from the providers pharmacy team. However, we found out of date urine analysis sticks on Wollaton ward.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute of Health and Care excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

Track record on safety

- This core service reported 18 serious incidents in the last 12 months prior to inspection.
- The most common reason for serious incidents was patient violence and aggression, with a total of eight incidents.

Reporting incidents and learning from when things go wrong

- Staff told us they knew what to report and how to report. Staff had reported all incidents that should be reported on an electronic database. We reviewed five incident reports, which confirmed this.

Inadequate

Forensic inpatient/secure wards

- Staff were open and transparent and explained to patients when things went wrong.
- Staff received feedback from the investigation of incidents both internal and external to the service. We saw evidence of this in team meeting minutes.
- Managers held daily morning meetings to discuss any serious incidents from overnight or the previous day. Actions from these meetings were shared with staff via email and in team meeting minutes.
- Managers told us about changes made following learning from incidents. These included to be more aware of individual patient needs and briefing police before they get involved with any patients.
- Managers debriefed staff and offered them support after serious incidents.

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Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Staff completed care plans that demonstrated good practice. We examined 24 care records for this service. Records were holistic and written in the patient's own voice, indicating their involvement in the assessment and care planning process. Staff had completed a comprehensive and timely assessment for each patient after admission.
- Staff had completed a physical examination for patients on admission and there was ongoing monitoring of physical health problems.
- Staff regularly updated care plans to reflect changes in patient needs.

Best practice in treatment and care

- Staff followed National Institute of Health and Care Excellence guidance when prescribing medication. Eleven of the patients we reviewed were prescribed antipsychotic medicines. Blood tests, investigations and physical observations were carried out in accordance with national guidance and best practice recommendations, and a record was kept on the electronic notes system for each patient. Two patients were prescribed high dose antipsychotic treatment, which carries a greater risk of adverse effects. In both cases, there was a clear treatment plan in place which was regularly reviewed by the responsible clinician. In addition, appropriate monitoring had been carried out to ensure the treatment remained safe and beneficial.
- Staff offered recommended psychological therapies for sex offender treatment and anger management.
- A dedicated physical healthcare team ensured patients had good access to physical healthcare. Staff told us they would refer to specialists when needed. Staff completed specific care plans for patients to support their physical healthcare needs, for example, diabetes management and epilepsy.
- Staff used the malnutrition universal screening tool. This was evidenced in care records reviewed. Newstead ward had a dysphagia care plan folder in the kitchen.
- The service promoted healthy living through sporting events, including a sports day and an inflatable assault course, which staff and patients participated in.
- Staff used recognised rating scales to assess and record severity and outcomes such as the health of the nation outcome scale for secure services.
- Clinical staff participated actively in clinical audit of care records. Staff updated care plans and positive behavioural support plans in line with these audits. The provider also conducted quarterly audits of clinic rooms and the electronic prescribing system.

Skilled staff to deliver care

- Managers had not ensured that staff on Thoresby ward had completed training in therapeutic communities. According to data from the provider only four staff on Thoresby ward had completed this training. The Royal College of Psychiatrists' service standards for therapeutic communities' states that "all staff receive training in therapeutic communities for a minimum of two days per year". We found evidence that staff were not practicing in line with accepted standards for therapeutic communities, for example, by ensuring patients had a signed contract to evidence they agreed to undergo the model of treatment.
- The provider had the full range of disciplines needed to deliver care including autism specialists, nurses, occupational therapists, clinical psychologists, social workers, healthcare assistants and activities coordinators.

- We spoke with a number of staff during inspection. They told us that they received an appropriate induction and healthcare assistants told us that the care certificate standards were used as the benchmark for their induction.
- Managers ensured that staff were appraised and had access to regular team meetings. The percentage of non-medical staff that had an appraisal in the last 12 months was 100%.
- Managers ensured staff were regularly supervised. The provider reported compliance rates of 91% for clinical supervision.
- The provider had a learning and development department providing staff access to the necessary specialist training for their roles. Some staff told us that the training team often provided training at a location at some distance from the service, which made it difficult for them to attend. However, the provider told us that training took place mainly on site and where it was not, overnight accommodation and expenses were paid.
- Staff told us they had access to training to support them in their roles, including in relational security, autism spectrum disorder, personality disorders, report writing, compassion focused therapy, sensory training, epilepsy and diabetes.
- We saw evidence in staff files that managers usually addressed poor staff performance promptly and effectively. However, we found some issues with staff practice that had not been identified and addressed.

Multi-disciplinary and inter-agency team work

- Staff participated in regular, effective multidisciplinary meetings. We observed one of these and a range of disciplines attended, including a healthcare assistant, who knew the patient well.
- Staff attended effective handovers within teams. Each ward had a dedicated handover template with key areas for staff to discuss for each patient at the start and end of each shift, including risks, behaviour, patient's presentation and a "positive message".
- Staff had effective working relationships with other teams and stakeholders. The provider met regularly with NHS England (who commission specialist healthcare placements) and the local police.

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

- Staff did not always comply with the Mental Health Act Code of Practice for patients in seclusion. Staff did not always complete the required reviews and observations. We reviewed records that indicated patients were being kept in seclusion for longer than required. On Thoresby ward patients voted on whether other patients should remain in seclusion. The provider had completed audits of seclusion records but had not identified these issues.
- The provider had a dedicated, centralised Mental Health Act team including an administrator who examined Mental Health Act papers on admission. Staff knew who the administrators were and could get support to ensure that they followed the Act in relation to, for example, renewals, consent to treatment and appeals against detention.
- Staff kept clear records of leave granted to patients. Patients, staff and carers were aware of the parameters of leave granted, including risk and contingency/crisis measures.
- The provider had developed a combined mandatory training module on The Mental Health Act (1983), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Ninety two percent of staff had completed this training.
- We saw that staff adhered to consent to treatment and capacity requirements and kept copies of consent to treatment forms attached to medication charts where applicable.
- Staff explained patients' rights under the Mental Health Act to them on admission and routinely thereafter. This was evident in patient records reviewed.
- Staff completed detention paperwork correctly, kept it up to date and stored it appropriately.
- Staff carried out regular audits to ensure that they applied the Mental Health Act correctly and there was evidence of learning from these audits.
- Staff ensured that patients had access to Independent Mental Health Advocate services. Staff were clear on how to access the advocacy service to support patients with capacity issues, or access to wards and records. Staff displayed posters with the names and contact details of the mental health advocacy services.

Good practice in applying the Mental Capacity Act

- Staff did not always demonstrate good practice in applying the Mental Capacity Act. We reviewed 24 patient records. Ten did not include evidence that staff had considered patient's capacity. Staff assumed

capacity and did not apply blanket capacity assessments but it was not evident that the multi-disciplinary team had discussed capacity in relation to patients consenting to treatment. Staff on Thoresby ward, which operated as a therapeutic community, had not completed capacity assessments for patients prior to their admission to the ward to ensure they understood the model of treatment. Patients were required to verbally agree to the terms of living within a therapeutic community, without staff being assured that they had the capacity to understand what this would mean. There was no written contract in place with patients. However, the provider advised after the inspection that they would start assessing the capacity of patients prior to admission to Thoresby ward and would introduce an informed consent form.

- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- The provider had a policy on the Mental Capacity Act (2005) including Deprivation of Liberty Safeguards which staff are aware of and can refer to on the intranet.
- Staff knew where to get advice regarding Mental Capacity Act, including Deprivation of Liberty safeguards. At the time of inspection all patients in the hospital were detained under the Mental Health Act (1983) and no Deprivation of Liberty safeguarding applications had been made.

Are forensic inpatient/secure wards caring?

Inadequate

Kindness, dignity, respect and support

- Staff did not always treat patients with kindness or respect when providing care and treatment or during other interactions. We observed a patient being 'pat down' searched in front of other patients in the communal area on Thoresby ward. This was not in line with the provider's search policy. We reviewed 16 records of patients in seclusion. Staff were not responding to patient's requests in 4 records reviewed. This included requests to go to the toilet, to use the shower, for food, medicines and for blankets. In one record, the patient had requested to use the toilet at 21:45. The patient repeated this request three times and at 22:30 soiled themselves. The staff records of this incident were disrespectful and used inappropriate language. A patient told us that they had witnessed a member of staff ignoring a request from a patient in seclusion for a drink.
- Patients told us that staff supported them to understand their condition. Patients on Thoresby ward said they found it beneficial for staff to give them more responsibilities.
- Patients told us that staff were friendly, approachable, caring, nice, helped them to progress, were good listeners, supportive and patient focused. However, patients on Wollaton ward told us that staff were sometimes punitive in their approach, would ignore them if they were settled, could be disrespectful and had breached confidentiality at times. On Thoresby ward, we observed a senior staff member ignore a patient, who called out to them three times.

Involvement of patients

- Staff ensured that the admission process informed and orientated patients to the ward and the service. Staff displayed posters in communal areas alerting patients to the daily activities and meetings for the ward.
- Patients told us they were actively involved in care planning and risk assessment and this was evident in care plans.
- Patients had access to advocacy and there were posters displayed giving details of how to make contact.
- Patients could give feedback on the service they received at twice weekly community meetings and via a patient feedback survey. We reviewed community meeting minutes on Newstead ward and saw evidence that patients set agenda items and staff took action, for example, making changes to bathroom flooring and trialling a new laundry rota. Advocacy helped to facilitate the community meetings once a week.
- Patients on Newstead ward were offered opportunities to help cleaning staff keep the ward clean and tidy. Patients would be given a voucher to use in the café once tasks were completed.
- Patients could be involved in decisions about the service and had been involved in the recruitment of staff.

Involvement of families and carers

- Carers told us they felt involved in their relative's care. One carer gave an example of raising a concern, which

staff had then acted on. However, one carer said that not all staff listened to them. There was a visitor's suite near the hospital entrance and families could also use the café with their relative. Carers were not able to visit their loved ones on the wards. This was not in line with current NHS England guidance for patients with a learning disability which states that services should "welcome family members to access their relative's room at any time, subject to the person's agreement".

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

(for example, to feedback?)

Good

Access and discharge

- The average bed occupancy over the last six months prior to inspection was 89%.
- The average length of stay for current patients was 778 days. This was highest on Wollaton ward, with an average length of stay of 1124 days and lowest on Newstead with an average length of stay of 541 days.
- The provider did not admit new patients to current patients' beds when they were on leave, ensuring patients always had access to a bed on return from leave.
- Staff did not move patients between wards during an admission episode unless this was justified on clinical grounds and in the interests of the patient. When staff moved or discharged patients this happened at an appropriate time of day.

Discharge and transfers of care

- The provider did not supply any data on delayed discharges. However, they were working closely with NHS England to review patients who were ready for discharge from the service, but were delayed due to lack of suitable placements in the community. We saw evidence that care and treatment reviews were taking place for patients.
- Care plans referred to identified section 117 aftercare services to be provided for those patients' subject to section 3 or equivalent Part 3 powers of the Mental Health Act (1983), authorising admission to hospital for treatment.

The facilities promote recovery, comfort, dignity and confidentiality

- All patients had their own bedroom with en suite facilities. The provider supported patients to personalise their bedrooms on all wards. Staff had individually risk assessed this to allow patients access to technology such as games consoles in their rooms, provided the patient consented to having their equipment appliance tested and internet access restricted.
- Patients could store most of their possessions in their rooms but there was also locked space provided for restricted items that the provider did not allow on the ward.
- The provider had a full range of rooms and equipment to support treatment and care and help patients build skills to support them when they moved on from services. The provider had a range of activity and therapy rooms, including a music room, information technology suite, therapy kitchens, gym, and arts and crafts rooms.
- The provider ensured there were quiet areas on the wards where patients could have time to think or pray and patients had access to a multi faith room. There was also a visitor's room where patients could meet with visitors.
- Patients could make a telephone call in private, each ward had a telephone in a private room.
- Patients had access to outside space, each ward had a garden and for most patients, access to fresh air was unrestricted. However, on Wollaton ward patients told us they had to request access to the garden from staff and a member of staff was required to stay with them in the garden.
- Patients told us that food was of an acceptable quality, patients could choose meals from a weekly menu, purchase food from the onsite café, or if individually care planned could shop and cook in the therapy kitchen. Patients had access to hot drinks and snacks 24 hours a day.

Patients engagement with the wider community

- Staff provided activities for patients on and off the wards, including at weekends. Staff displayed activities planners for patients to see on all wards.

Meeting the needs of people who use the service

Inadequate

Forensic inpatient/secure wards

- Whilst wards were not fully equipped to support disabled access the provider designed support packages to meet individual mobility needs.
- Staff ensured patients could obtain information on treatments, rights and how to complain. We saw this information displayed on the wards.
- Staff provided accessible information on treatments, local services, patients' rights, and how to complain.
- The provider used interpreters to ensure patients could communicate if they did not speak or understand English, they also worked with catering so that they met patient cultural needs with respect to diet.
- Staff ensured they met individual patient dietary needs, for example, halal, kosher and vegetarian diets.
- The provider had a RACE (Race, Culture and Ethnicity) group who looked at ways they could support patients from different ethnic backgrounds.

Listening to and learning from concerns and complaints

- The provider actively reviewed complaints and involved patients and staff in responding and resolving them and improvements were made as a result across the service. An example was staff supporting a patient to call his mum every evening after his mum complained that he was not calling her. The provider reported that there were 27 complaints in the twelve months prior to the inspection. The provider upheld twelve of the complaints referred none to the ombudsman. Eleven of these complaints were from Rufford ward, two of which the provider upheld regarding section 17 leave not being signed off and staff keeping a patient awake at night.
- The service also received 13 compliments during the same period. Wollaton ward received the most compliments with nine.
- Two patients told us that they had made complaints and that staff had responded appropriately and acted to address their concerns.
- Staff knew how to handle complaints appropriately. The provider investigated complaints promptly and staff received feedback on the outcome of investigation of complaints and acted on the findings. There was evidence of this in team meeting minutes and care records.

Are forensic inpatient/secure wards well-led?

Inadequate

Leadership

- Leaders had not ensured a safe and caring service. We identified serious issues in relation to keeping patients in seclusion for longer than Mental Health Act Code of Practice recommendations. Leaders had not identified poor practices in relation to staff ignoring patients' requests and using inappropriate and disrespectful language in care records. Leaders told us they were working towards accreditation for the therapeutic community against the Royal College of Psychiatrists standards. However, at the time of our visit a number of these standards were not being met Leaders had not provided training or ensured staff were equipped to work within the standards expected of a therapeutic community. Leaders had not ensured that patients were fully aware of and able to consent to the model of treatment in the therapeutic community.
- Not all leaders had the skills, knowledge and experience to perform their roles. The provider had introduced a new approach aimed at providing the best patient outcomes and involving the introduction of integrated practice units to provide care to patients with similar clinical needs. The provider had introduced new leadership roles in April 2018 to oversee the integrated practice unit at Nottinghamshire. The provider had recently appointed three of the four ward managers. They told us they had been supported to develop their skills and knowledge through leadership courses and support from senior managers.
- We received mixed feedback from staff regarding the visibility of leaders in the service. Some staff reported that leaders were visible and approachable, whereas others said they never saw them on the wards. We observed that patients knew the senior staff at the service.
- Staff told us that leadership opportunities were available through the providers internal training team.

Vision and strategy

- Staff knew and agreed with the organisation's vision: to transform lives together. The values which underpin the

vision and the provider's strategy were; compassion: be supportive; understand and care for patients, their families and all in the community. Accountability: take ownership; be proactive, be responsible, do what you say you will do. Respect: Act with integrity; be real, be open, be honest. Excellence: innovate, learn and deliver; whatever you do, do it well.
- Managers ensured that team objectives reflected the organisation's vision and values. Managers displayed their wards values on the walls in patient areas.

Culture

- Most staff felt respected, valued and supported.
- Staff told us they knew how to use the whistleblowing process and felt able to raise concerns without fear of victimisation.
- Managers did not always identify poor staff performance.
- Teams worked well together and managers had changed shift arrangements to enable staff to work better as a team.
- Sickness and absence rates amongst permanent staff were highest on Newstead ward at 19%, between 01 August 2017 and 31 July 2018. This had improved when we were on site as staff had returned from long term sickness absence. Rufford ward had the lowest sickness rate at 9%.
- Staff told us the provider had excellent resources for external staff support such as counselling services and occupational health. Two managers had introduced flexible rostering on their ward. Staff told us that this had improved their work life balance and wellbeing.
- The provider held annual care awards across all services. Staff could nominate colleagues for one of these awards, based on the providers values. The complaints department had nominated the manager of Newstead ward for an award for her caring approach to a patient's complaint.

Governance

- Leaders and governance arrangements had not assured the delivery of high quality care. The provider's governance processes had not ensured all staff followed best practice in the care and treatment of patients. Managers had not ensured that all staff worked within the legal frameworks of the Mental Health Act and Mental Capacity Act. We identified staff practices in breach of both these acts and use of inappropriate language in one patient's care record. The provider's governance processes had not highlighted these issues.
- Managers ensured that staff received mandatory training and annual appraisals.
- Staff participated actively in clinical audits and patients were also involved in suggesting which aspects of care should be prioritised for audit.
- Staff reported incidents and managers ensured that staff learnt from incidents, complaints and service user feedback. Managers had also introduced 'green top alerts' to share examples of good practice across the service.
- Ward managers told us they had sufficient authority to do their job and staff had the ability to submit items to the provider's risk register.

Management of risk, issues and performance

- Staff were able to access the risk register and could escalate concerns when required.
- The service had business continuity plans to manage emergency situations, for example, adverse weather events.

Information Management

- The provider used systems to collect data from wards that were not over burdensome on staff.
- Staff had access to the equipment and technology they needed to do their work.
- The provider used key performance indicators to support managers to gauge the performance of their teams, including compliance with training, supervision and reduction in restrictive interventions. The provider told us they were refining this system to provide better quality information.
- Staff made notifications to external bodies as needed.

Engagement

- Staff had access to up to date information about the work of the provider through the intranet, emails and newsletters.
- Patients and carers had opportunities to feedback about the service through questionnaires and meetings. The provider employed a dedicated involvement lead to oversee this work.

Inadequate

Forensic inpatient/secure wards

- Staff had opportunities to meet the providers senior leadership team through 'drop in' sessions. Staff told us they had recently met the new chief executive when they had visited the service.
- Senior leaders engaged with external stakeholders, for example NHS England and Clinical Commissioning Groups.

Leadership, continuous improvement and innovation

- Managers offered staff the opportunity to give feedback on services and input into service development.
- The service was a member of the Quality Network for Forensic Mental Health Services and was reviewed annually by their peers. The last review was in February 2018 and identified that the service needed to prioritise training, improve engagement with friends and families, improve communication with staff and review blanket restrictions. The provider told us that work was underway to address these actions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure compliance with the Mental Health Act Code of Practice in relation to seclusion practices.
- The provider must ensure compliance with the Mental Capacity Act.
- The provider must ensure safe environments, through identification and mitigation of risks and adherence to infection control standards.
- The provider must ensure staff treat patients with kindness and respect and respond to their needs in a timely manner.
- The provider must ensure governance processes identify and address areas of poor practice.
- The provider must ensure the therapeutic community operates within recognised standards.
- The provider must ensure staff receive specialist training in relation to restraint and therapeutic communities.

Action the provider SHOULD take to improve

- The provider should ensure carers can access patients' accommodation.

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 11 HSCA (RA) Regulations 2014 Need for consent • Staff were not compliant with the Mental Capacity Act. We reviewed 24 patient records and ten had no evidence that staff had assessed capacity. • Staff on Thoresby ward, operating as a therapeutic community, were not completing capacity assessments with patients prior to their admission to the service. There was no evidence in patients records that they had consented to undergo the model of treatment provided on the ward. This was a breach of regulation 11

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had not ensured all staff working on Thoresby ward received training in therapeutic communities. This was a breach of regulation 18

This section is primarily information for the provider

Enforcement actions

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 10 HSCA (RA) Regulations 2014 Dignity and respect • Staff did not always treat patients with kindness or respect when providing care and treatment or during other interactions. We observed a patient being 'pat down' searched in front of other patients in the communal area on Thoresby ward. Staff were not responding to patients requests when in seclusion. Staff records in one instance, were disrespectful and used inappropriate language. • Patients told us that some staff were punitive, disrespectful and sometimes ignored them. This was a breach of regulation 10

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 • Staff were not compliant with the Mental Health Act Code of Practice. Doctors and nurses were not always completing reviews as required. Staff were not always completing observations. Staff had not always completed seclusion care plans. • Managers had not ensured safe environments. We found unidentified ligature risks on Newstead ward and an out of date ligature assessment available for staff on Thoresby ward. We identified a blind spot and a scratched viewing lens in the ensuite areas of

This section is primarily information for the provider

Enforcement actions

Newstead and Rufford seclusion rooms. On Wollaton ward, staff were not adhering to infection control principles when dealing with laundry and clinical waste.

- Management of actual and potential aggression training did not enable staff to intervene to keep all patients safe.
- The provider had not ensured staff working on Thoresby ward had the specialist training to support patients safely.

This was a breach of regulation 12

Regulated activity	Regulation
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 • Staff permitted patients on Thoresby ward to vote on whether another patients seclusion could be ended or not. • Staff were keeping patients in seclusion for longer than required. This was a breach of regulation 13

Regulated activity	Regulation
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 • Leaders and governance arrangements had not assured the delivery of high quality care. Managers had not ensured that all staff worked within the legal

This section is primarily information for the provider

Enforcement actions

frameworks of the Mental Health Act and Mental Capacity Act. We identified staff practices in breach of both these acts and use of inappropriate language in one patient's care record.

- Leaders did not ensure compliance with recognised standards. Leaders told us they were working towards accreditation for the therapeutic community against the Royal College of Psychiatrists standards. However, at the time of our visit a number of these standards were not being met. Leaders had not provided training or ensured staff were equipped to work within the standards expected of a therapeutic community. Leaders had not ensured that patients were fully aware and able to consent to the model of treatment in the therapeutic community.

This was a breach of regulation 17