Partnerships in Care Limited

Priory Hospital Enfield

Inspection report

15 Church Street
Edmonton
London
N9 9DY
Tel: 02089561234
www.partnershipsincare.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Overall summary

Our overall rating for the service stayed the same. We rated it as Requires Improvement because:

There were lots of staff vacancies and the services relied on temporary staff to ensure the wards were safely staffed. This affected the continuity of care for patients, who reported that they were not always familiar with the staff who cared for them.

Staff on the forensic wards did not always make the necessary physical health checks when patients had received medicines by intramuscular rapid tranquilisation. This meant that potentially harmful physical health deterioration may not be identified and acted on by staff.

Staff had not taken any action to escalate problems with emergency alarms not working in two bedrooms on Coleridge ward a forensic service. This meant that staff or patients requiring assistance in an emergency in these rooms would not be able to call for assistance.

Patients on Blake ward, the acute ward for adults of working age, reported that there were not enough therapeutic activities to keep them occupied and they did not have access to support from an occupational therapist. Patients on the forensic wards reported that there were not enough activities to keep them occupied during evenings and at weekends.

The forensic mental health ward environments were not therapeutic in nature and the provider had made very limited progress in improving the ward environments since the last inspection.

The service had not yet made much progress with its approach to reducing restrictive interventions, like restraint and seclusion. The reducing restrictive interventions project group was newly formed and was not systematically reviewing themes and trends from data about the use of restrictive interventions.

Some concerns identified during the inspection had not been identified by the provider through their internal governance assurance processes.

However;

The ward environments were clean. Blake ward had recently opened as a new acute mental health ward. The provider had completed a robust programme of environmental works to ensure the ward was fit for its intended use.

Patients told us they had good therapeutic relationships with the regular staff who worked on the wards.

Patients were encouraged to give feedback on their experience and the quality of the service. They also contributed to discussions about their care and treatment and were given treatment options where appropriate.

A positive staff culture meant that staff felt well supported in their roles and could access support from colleagues. Leaders were committed to delivering a high-quality service and supporting staff. They managed to provide enough support to staff and oversight of wards despite some ward manager posts not being filled at the time of the inspection.

Summary of findings

Improvements had been made since the last inspection. These included learning from incidents, patients knowing how to access IMHA, and access to personal emergency alarms.

Different members of the multi-disciplinary staff team were dedicated to supporting patients in their recovery. They explained how they tailored their approach to individual patients and supported patients to re-integrate to the community and boost their skills and experience where appropriate.

Staff held close professional links with colleagues in other agencies and teams which helped them plan for effective patient discharge.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good 	Blake Ward had been refurbished to a high standard prior to reopening as an acute ward for working age adults in the summer of 2019. Staff spoke positively about the practical and emotional support provided by staff and support to understand and manage their own care, treatment or condition. Patients said staff treated them well and behaved kindly and they felt safe on the ward. Patients told us that staff listened to feedback. Staff recorded detailed, comprehensive, and holistic care plans and risk assessments for patients on the ward, with some evidence of patient involvement. Staff identified patients' physical health needs and monitored patients' physical health using National Early Warning Score charts, identifying when specialist input was required, for example a dietitian to ensure that dietary and hydration needs were met. Staff spoke positively about support from senior managers and the ward manager and deputy, and they described good multi-disciplinary team work on the ward. Staff were able to tell us about learning from incidents on the ward, and within the wider provider organisation. We spoke with one family member of a patient on the ward, who spoke positively about their involvement in their relative's care, and inclusion in ward meetings via a video call. However: The service did not provide enough therapeutic activities for patients. There was no occupational therapist in place at the time of the inspection and patients complained that they were often bored. There were also no group psychology sessions in place and patients did not have routine access to a computer with internet access.

Summary of findings

			There were significant staff vacancies on Blake Ward although there was an ongoing recruitment programme in place, leading to some difficulties finding substantive staff cover for the ward at all times. A large quantity of a controlled medicine was identified on Blake ward that should have been safely destroyed when it was no longer required, approximately two months before the inspection. Not all staff were aware of the provider's procedures for the safe destruction of controlled medicines. The medicine had been stored safely and was destroyed promptly when we notified the provider. There were problems with the ventilation on Blake Ward which had led to the ward being overly hot during the summer months. Staff did not always record that they had repeated rights under Section 132 of the Mental Health Act to patients after their admission, as necessary to ensure that they had understood them, or best interest decisions for patients who lacked capacity to consent to treatment.
Forensic inpatient or secure wards	**Requires Improvement**		Staff did not always monitor patient's physical health to detect potential deterioration when they had received medicines by intramuscular rapid tranquilisation. We identified one example where a patient living with a significant long-term physical health condition had not been subject to routine physical health monitoring after receiving antipsychotic medicine via intramuscular rapid tranquilisation. Staff had not taken any action to escalate problems with emergency alarms not working in two bedrooms on Coleridge ward, despite them being checked and recorded by staff as not working for weeks before the inspection. This meant that staff or patients requiring assistance in an emergency in these rooms would not be able to call for assistance if needed. Challenges with staff recruitment and retention were ongoing. Some staff and patients reported that Section 17 leave was often re-arranged at short notice because staff were too busy to facilitate it as planned. Staff shortages were

Summary of findings

identified during the last inspection in April 2018 and this continued to be a challenge. Leaders were working hard to reduce the number of vacant posts across the hospital.

The ward environments continued to appear sterile and were not therapeutic in nature, despite this being identified as needing attention during the last inspection in April 2018. This issue continued to feature as one of the top risks on the hospital risk register and not much progress had been made.

The service had not made much progress with its reducing restrictive interventions programme. The reducing restrictive interventions project group was newly formed and was not systematically reviewing themes and trends from data about the use of restrictive interventions.

Some patients reported that there were not enough activities to keep them occupied at evenings and weekends.

Some issues identified during the inspection had not been identified by the provider's internal governance assurance processes. These included discrepancies with patient risk assessments, emergency alarms not working, inconsistencies with how general observations were recorded and an issue with medicines storage.

However,

Some improvements had been made since the last inspection. Staff now systematically learnt from incidents and complaints, patients knew how to contact the independent mental health advocate and there were now enough personal emergency alarms for staff to wear.

The ward environments were safe and clean, and staff followed good practice with respect to safeguarding. Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.

Although the ward teams had access to the full range of specialists required to meet the needs of patients on the wards, there were some staff vacancies within these specialist disciplines, such as occupational therapy and psychology. This

Summary of findings

meant that these staff needed to carefully prioritise their workloads and work across multiple wards. Managers ensured that staff received training, supervision and appraisal. All staff worked well together as a multidisciplinary team. Staff worked very closely with colleagues at other providers through the North London Forensic Consortium, to help plan for discharge and aftercare. Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

Face to face feedback clinics had been introduced by the complaints manager, which has improved patient satisfaction and resulted in a reduction in formal complaints. Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason. Staff supported patients to integrate with the wider community and supported patients to develop their skills and experience to help them secure potential employment in future.

The service was led by a dedicated and skilled senior team. Senior staff were dedicated to supporting ward staff as best as they could whilst arrangements were being made to cover the ward manager posts on Byron and Coleridge ward. The staff culture was positive. Staff reported that they enjoyed working at the service, felt well supported and valued by their colleagues and were able to raise concerns without fear of retribution.

Summary of findings

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Summary of this inspection

Background to Priory Hospital Enfield

Priory Hospital Enfield is a 53 bed independent mental health hospital consisting on three male-only forensic mental health wards. Coleridge and Keats wards are medium secure. Byron ward is low secure. Blake ward is a mixed-sex acute mental health ward for adults of working age. This ward opened in 2019, after the last inspection. This was the first inspection of the acute wards for adults of working age core service.

The service was last inspected in April 2018 and received an overall rating of requires improvement, with domain ratings of requires improvement for safe, effective and well led, and good for caring and responsive.

The service had a registered manager in place when we inspected.

The provider is registered to provide the following regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983, Diagnostic and screening procedures, and Treatment of disease, disorder or injury.

How we carried out this inspection

The inspection team comprised three CQC inspectors, one CQC inspection manager, one CQC Mental Health Act reviewer, one expert by experience and two specialist advisors with clinical backgrounds in mental health nursing.

Before the inspection visit, we reviewed information we held about the service.

During the inspection, the inspection team:

- Conducted a detailed tour of all four ward environments and associated seclusion facilities
- Spoke with 19 patients
- Reviewed 23 patient care and treatment records
- Spoke with the hospital director, director of clinical services and medical director
- Spoke with two ward managers
- Spoke with 23 staff including doctors, nurses, nursing assistants, occupational therapists, psychologists and social workers.
- Reviewed a range of policies, procedures and other documentation relating to the day to day running of the service.

Areas for improvement

Actions the provider must take to improve the service:

The provider must ensure staff complete the necessary physical health monitoring of patients who receive medicines by intramuscular rapid tranquilisation, to protect patients from significant physical health deterioration.

The provider must ensure staff always identify and escalate instances of emergency alarms not working in a timely manner to help ensure staff and patients can always call for help in an emergency.

Summary of this inspection

The provider must ensure that support from occupational therapists is made available within the Acute wards for adults of working age core service on Blake ward.

The provider must continue its work to reduce the number of vacant posts across the hospital and reduce its reliance on temporary staff to improve the continuity of care of patients.

The provider must improve the therapeutic nature of the forensic ward environments.

Actions the provider should take to improve the service:

The provider should ensure that all relevant staff are aware of and compliant with the provider's procedures for the safe destruction of controlled medicines, and that there are improvements in the auditing of stocks of controlled medicines.

The provider should prioritise embedding its local reducing restrictive practice programme to help ensure patients are treated with the least restrictive intervention being applied to them as possible.

The provider should ensure that the problems with ventilation on Blake Ward are addressed without delay.

The provider should review its therapeutic activity provision on the Forensic wards at evenings and weekends.

The provider should ensure that detained patients have their rights under Section 132 of the Mental Health Act repeated after their admission and repeated as necessary to ensure they have understood them.

The provider should ensure best interest decisions for patients who are assessed as lacking consent to treatment are recoded. The provider should review its policy relating to internet access on Blake ward.

The provider should review the provision of psychology intervention for patients on Blake ward.

The provider should review whether the specialist training available to staff appropriately covers the key areas of their work. The provider should give special consideration to training in working with autistic people and people who have a learning disability.

The provider should take action to review effectiveness of the internal governance assurance framework to ensure they are fit for purpose and highlights issues requiring attention to senior staff.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Requires Improvement	Good	Good
Forensic inpatient or secure wards	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Overall	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement

Acute wards for adults of working age and psychiatric intensive care units

Good

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

Are Acute wards for adults of working age and psychiatric intensive care units safe?

Good

Safe and clean care environments

The ward was safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified.

Staff were supported by CCTV and concave mirrors around the ward to observe patients and ensure their safety. Sight lines in the corridor where the bedrooms were located were partly restricted by fire doors on each side. Staff told us that a member of staff was always present on this corridor to help mitigate this risk. Staff knew about potential ligature anchor points and told us how they mitigated the risks to keep patients safe. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. They were clear about where to access ligature cutters if needed. There were current general risk assessments for the ward, and a current ligature risk assessment for the ward from July 2021.

The ward complied with guidance and there was no mixed gender accommodation. There were separate areas for male and female bedrooms, all rooms had en-suite shower and toilet facilities and there was a small female only lounge. However, this was in an area that could only be accessed with staff supervision and staff reported that it was rarely used.

Staff carried alarms with them, and patients had easy access to nurse call systems in their bedrooms.

The ward was spacious and well decorated. However, there was a leak from the roof, leading to one bedroom being out of service. This was being addressed at the time of the inspection. Staff also advised that there were problems with the ward's ventilation, which had led to it being very hot over the summer.

Maintenance, cleanliness and infection control

Acute wards for adults of working age and psychiatric intensive care units

Good

Ward areas were clean, well maintained, and well-furnished. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing and completed enhanced infection control checklists every morning, afternoon and night. There was a maintenance log in place for the ward, and we noted that issues reported were responded to swiftly.

There were clear policies for staff to follow during the Covid-19 pandemic. This included testing for all patients on admission, and isolation for any patients showing symptoms of infection. All staff were carrying out lateral flow tests two to three times weekly.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment and kept up to date records of this. All equipment was appropriately calibrated, with weekly clinical room checks recorded by the nurse in charge, and a pharmacist. A defibrillator and a crash bag including ligature cutters was readily available, and all medicines were in date.

There was one large oxygen cylinder in the clinic room which was not strapped to the wall. This had been identified prior to the inspection and was addressed at the time of the inspection.

Safe staffing

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

Nursing staff

During the inspection, the ward had enough staff to meet the needs of patients. There were nine patients on the unit, with eight staff supporting them (including two patients receiving one-to-one support and one agency staff member). Some staff said that vacancies, sickness, and Covid-19 restrictions meant that they were occasionally understaffed (for short notice cover) and this could increase the risk on the ward.

Staff advised that for a full ward, the minimum staffing was two registered and two non-registered nurses, and that this was the same at night-time. The ward manager could adjust staffing levels according to the needs of the patients. At the time of the inspection, there was also an extra staff member on duty for security due to the scaffolding on the roof of the unit.

The service had high vacancies for nursing staff. Out of an establishment of eight registered nurses, there was one nurse substantive role in place, and out of 20 non-registered nurses, there were 8.4 substantive roles in place. However, there were a substantial number of bank (as and when) staff working on the ward, limiting the number of agency workers needed to fill shifts.

The staffing rotas showed that most shifts were filled, although highlighted a reliance of bank and agency staff. In the last year, 645 out of 4,380 shifts had been covered by regular bank staff, and 2,530 had been covered by agency staff. There were 144 shifts that had not been filled. When using agency staff, managers requested staff familiar with the service whenever possible and they were employed on rolling-contracts for continuity. Some agency staff had worked on the ward for extended periods of time. Staff told us that they could call for extra support from another ward when needed, and senior staff would also help. They told us that they would complete an incident report for any unfilled shift.

Acute wards for adults of working age and psychiatric intensive care units

Good

Patients rarely had their escorted leave cancelled, even when the service was short staffed. Patients usually had regular one-to-one sessions with their named nurse. The service had enough staff on each shift to carry out any physical interventions safely.

Managers were aware of the need to recruit more permanent staff and ensure that temporary staff were inducted to the ward. The service was in the process of recruiting that more staff. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had a high turnover of staff. Across the hospital, the turnover of staff in the last year was 27.8%. Managers supported staff who needed time off for ill health. Across the hospital levels of sickness were 5.3% in July 2021.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There was a consultant dedicated to the ward who attended at least weekly, in addition to a ward doctor who attended daily, and on call doctor available out of hours. We spoke with the ward consultant and specialist doctor, who were both satisfied with the medical support available on the ward.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. Over 75% of staff had completed all mandatory training courses, with the exception of fire safety training which was at 66%. The ward manager had a plan in place to ensure that compliance with fire safety training was addressed promptly. Agency staff were encouraged to undertake training in prevention and management of violence and aggression through the provider organisation.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this on a daily basis, and after any incident. They completed individual risk assessments for each patient in terms of any support needed with evacuation in the event of a fire.

They also completed general risk assessments for the ward including managing violence, risks in different locations, such as the car park, and managing clinical waste.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. They identified and responded to any changes in risks to, or posed by, patients.

Acute wards for adults of working age and psychiatric intensive care units

Good

Staff could observe patients in all communal areas of the ward and followed procedures to minimise risks in private areas including regular observations at a frequency depending on each patient's risk.

There was a clear list of prohibited items, including plastic bags, which were not allowed to be brought onto the ward for safety reasons. Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff noted what patients were wearing before going out on leave, to aid their return in the event of them going absent without leave. Staff also carried out regular drug testing of patients where this was indicated.

Records indicated a high standard of physical health monitoring with clear directions for when staff should seek medical advice about each patient.

Use of restrictive interventions

Levels of restrictive interventions were low. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Staff were able to describe the physical health checks that they would carry out immediately following rapid tranquilisation, although the ward used rapid tranquilisation very rarely and it had not used this in recent months. There was no seclusion facility for patients to use. If a patient was likely to require the use of seclusion facilities, staff told us that they would a transfer them to a psychiatric intensive care unit.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role and kept up-to-date with their safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. One staff member spoke of how they had supported a patient who had concerns about homophobia from other patients.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies including the local authority safeguarding team to protect them. Staff knew how to make a safeguarding referral and knew the safeguarding lead to inform if they had concerns, and they gave examples of when they had done so. For example, one staff member described making a safeguarding alert when a patient told them they had taken drugs in front of a child.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. Most patient records were electronic except for physical health monitoring records which were still in a paper format. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Records were stored securely.

Medicines management

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

Staff followed systems and processes when safely prescribing, administering, and recording medicines. Doctors reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines in ward rounds. We looked at medicines charts for five patients on the ward, and found that these were completed accurately with no gaps, and allergies recorded as appropriate. Staff informed the ward doctors when patients refused their prescribed medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy and followed current national practice to check patients had the correct medicines. However, during the inspection we found a large quantity of a controlled medicine that had not been disposed of, despite the patient having been discharged from the ward two months earlier. Due to a recording error, this was no longer being checked on each shift. This had not been picked up by the ward's medication audit or external pharmacy audit (conducted weekly). Staff on the ward addressed the issue promptly once this was brought to their attention.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. Staff stored physical health monitoring records alongside the medicines administration records to ensure that physical side effects of any medicines were monitored appropriately.

Track record on safety

The ward had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them, and gave us examples of incidents they had reported, including short staffing, patients fighting, and safeguarding concerns. Blake Ward had 18 incidents reported during the month of June 2021. Ten of these were related to staffing issues. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. The ward had no never events since it opened. Staff were able to describe the duty of candour. They told us that they gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. They investigated incidents thoroughly and staff told us that they received feedback from the investigation of incidents, both internal and external to the service. Staff told us that they received a lessons learned bulletin from the provider, and they kept a folder with up to date information including recent safety alert bulletins.

Acute wards for adults of working age and psychiatric intensive care units

Good

The service had made changes as a result of feedback from incidents. For example, staff described learning from an incident when two patients were agitated, leading to a change in practice in using a different exit on the ward to avoid making the situation worse.

Are Acute wards for adults of working age and psychiatric intensive care units effective?

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Patient records were detailed and comprehensive. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery-orientated with four sections covering 'keeping safe,' 'keeping healthy,' 'keeping connected, and 'keeping well.' These were recorded on the provider's electronic records system with paper records for physical health and fluid charts.

Staff told us that they regularly reviewed and updated care plans when patients' needs changed, and this was confirmed in the 11 patient records we looked at.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff provided a range of care and treatment suitable for the patients in the service and delivered care in line with best practice and national guidance. COVID-19 testing, isolation and vaccination processes were in place.

Staff identified patients' physical health needs and recorded them in their care plans. They kept records of patients' physical health and monitored physical health regularly using National Early Warning Score charts. They made sure that patients had access to physical health care, including specialists as required, for example a dietitian to ensure that dietary and hydration needs were met.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. They offered patients the opportunity to see a smoking cessation specialist, and access nicotine replacement therapy.

Staff took part in clinical audits, and managers used results from audits to make improvements. Staff had access to quality assurance dashboards including current information about performance with medicines administration, infection control procedures, care plans, risk assessments, and the Mental Health Act 1983.

Acute wards for adults of working age and psychiatric intensive care units

Good

Skilled staff to deliver care

The ward team included a range of specialists required to meet the needs of patients on the ward. However, at the time of the inspection there was no occupational therapist in post on the ward. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. They gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work and monthly one to one supervision sessions. We looked at four members of staff supervision records and found that staff had an opportunity to raise any concerns during these sessions. Regular bank and agency staff were also provided with supervision.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Minutes of recent team meetings indicated that topics discussed included care manner, the visiting policy, prevention and management of violence and aggression, and physical health checks on patients. Staff spoke positively about team work on the ward and support provided by their line manager. They noted that managers monitored the hours they worked, and ensured that they had breaks, and utilised their annual leave. However, they noted that there was some staff burn out, leading to increased turnover, particularly after working through the Covid-19 pandemic.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers had identified further training that they wanted staff to undertake in mental health, substance misuse, management of acute patients, and communication and engagement. They were in the process of arranging this training for all registered and non-registered nurses in the team. Most staff also told us that they had not had any training on working with autistic people or people who had a learning disability.

Multi-disciplinary and interagency team work

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

The multi-disciplinary team consisted of a consultant psychiatrist, a specialist doctor, and a recently appointed clinical psychologist. The ward was in the process of recruiting a new occupational therapist (OT) but had some access to support from an assistant OT. At the time of the inspection there were no formal outcome measures recorded by the OT team.

The clinical psychologist was able to work one day weekly on the ward following a period of time with not access to clinical psychology for patients. They were seeing two referred patients weekly on an individual basis and planned to set up some groups for patients as well. They also provided a reflective practice group for staff. Staff from all disciplines spoke positively about the team work on the ward, and support from their colleagues. They advised that they could arrange a GP, dentist, or other relevant health appointments for patients as needed.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings held twice daily.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff told us that they had access to support and advice on implementing the Mental Health Act and the Code of Practice.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Information about the advocacy service was posted on the notice board in the dining room on the ward.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand. However, we found two patients on the ward whose records did not evidence that their rights had been repeated after being explained on the day of their admission. One of these patients expressed that they had been particularly distressed at the start of their admission and could not recall being told about their rights.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits with the findings made available to all staff.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and staff we spoke with had a good understanding of the five principles.

There was a clear policy on Mental Capacity Act which staff knew how to access, and they also knew where to get accurate advice on the Mental Capacity Act within the provider organisation. Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We observed

mental capacity assessments recorded for patients where there was any doubt about their ability to consent to treatment. However, in the records of two patients, the assessment conclusion was contradictory: stating that the patient lacked capacity to consent to treatment but was consenting to it. This issue was discussed with the ward manager during the inspection.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Are Acute wards for adults of working age and psychiatric intensive care units caring?

Good

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. We spoke with six patients and one relative as part of this inspection. Patients told us that staff gave them help, emotional support and advice when they needed it and supported them to understand and manage their own care treatment or condition. One patient told us that staff were particularly helpful in supporting them to feel more balanced emotionally. Patients said that staff were busy but they made time to talk with patients. However, all patients said that there were few activities on the ward, and they often felt bored.

Patients said staff treated them well and behaved kindly and they felt safe on the ward. We observed caring and supportive interactions between patients and staff. Patients told us that the staff were very helpful. Staff we spoke with understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. One staff member told us about how they supported a patient who felt that they were experiencing homophobia from other patients, and how the service had a zero-tolerance policy on such behaviour.

Staff followed policy to keep patient information confidential and arranged to speak with patients in one of the ward's private rooms when needed.

We observed that staff had arranged a birthday cake for one patient during the inspection, shared by all patients, and that they were encouraged to celebrate this day with family as far as possible.

Patients and the relative we spoke with told us that staff listened to feedback, and tried to make changes to the ward accordingly, for example in arranging some trips away from the ward for patients.

Involvement in care

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

Acute wards for adults of working age and psychiatric intensive care units

Good

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. There was a 'Meet our nurses,' board with photographs of permanent staff on the ward displayed near the ward's reception. All patients received a welcome pack on admission. This included the ward's commitment to support patients to make their own choices, work towards independence, and feel good and proud. It had information on what to expect on the ward, including staff roles, meal times, medicines management and how to make a complaint or give feedback.

Staff involved patients and gave them access to their care plans and risk assessments. Care plans were generally detailed and holistic, indicating some patient involvement and views, although these were sometimes quite minimal.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. There was a board posted in the patient's lounge with information on 'You said, We did,' feedback on requests made by patients. This included requests for trips to a local park which were being facilitated, and a request for singing sessions, for which the ward had purchased a karaoke machine. Requests for air conditioning on the ward, therapy sessions, and more weekend activities were still being addressed by the ward management. Ventilation on the ward was due to be addressed, and a clinical psychologist had recently started work on the ward, with a view to starting some group therapy sessions. An occupational therapist was being recruited for the ward, and staff were attempting to facilitate more weekend activities, although they reported limited interest from many patients when they did so.

There were weekly community meetings held on the ward for patients during which staff ensured that each patient knew who their 'named nurse' was and had been able to meet with them. Minutes of these meetings indicated that when patients raised maintenance issues such as issues with their televisions and plumbing problems, these were addressed quite swiftly. Some patients also raised concerns around staff attitude and insufficient activities, and a wish to be able to raise anonymous complaints. The ward manager had plans in place to address these issues, including forthcoming staff training around engagement and communication.

Staff made sure patients could access advocacy services, with contact information made available to them as appropriate.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers and encouraged families to give feedback on the service. We spoke with one family member of a patient on the ward, who spoke positively about their involvement in their relative's care, and inclusion in ward meetings via a video call. Staff advised that some carers/family members chose to join ward rounds by phone, and others preferred a video call.

Patients were able to receive visitors in the visiting room on the ward. There was an appointment system in place, with a maximum of two visitors because of Covid-19 restrictions. At the time of the inspection, visitors were able to visit the ward by appointment but were encouraged to meet relatives away from the ward where possible. Some patients preferred to meet relatives in the car park or grounds of the hospital.

Staff gave carers information on how to find the carer's assessment, and there was a monthly carers' newsletter, with up to date information about the hospital.

Acute wards for adults of working age and psychiatric intensive care units

Good

Are Acute wards for adults of working age and psychiatric intensive care units responsive?

Requires Improvement

Access and discharge

Staff managed beds well. A bed was available when needed. Discharge was sometimes delayed due to lack of appropriate accommodation with patients often coming from far distances around the UK.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. However, due to having a significant number of patients on the ward from outside of the local are, staff reported some delays in discharging patients with complex needs.

When the ward opened in the summer of 2019, initially it had been block-purchased by local mental health trusts for their patients. But at the time of the inspection, all beds were purchased on a case by case basis from mental health trusts around the country including Wales.

Managers and staff worked to make sure they did not discharge patients before they were ready. However, they were rarely able to intervene if a patient was recalled by their local mental health trust who funded their placement.

When patients went on leave there was always a bed available when they returned. Staff worked to avoid moving or discharging patients at night or very early in the morning.

There was no psychiatric intensive care unit (PICU) within the hospital, and if needed, patients would be transferred to the nearest available hospital with an appropriate PICU bed available.

At the time of the inspection two patients were on leave, and one female bedroom was out of use due to the roof leaking, leaving nine patients on the unit, and the two rooms for patients on leave were kept open to them only.

Discharge and transfers of care

Managers monitored the number of delayed discharges. They reported some delayed discharges due to a lack of suitable accommodation, particularly for patients without a UK home address, or diagnosed with a personality disorder. Length of stay varied between approximately seven days and three months. The longest stay on the ward at the time of the inspection was 2.5 months due to a lack of suitable accommodation available.

Where possible, staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. However, there were times when patients were recalled to their funding NHS hospital trust at short notice. Staff supported patients when they were transferred between services following national standards for transfer.

Facilities that promote comfort, dignity and privacy

Acute wards for adults of working age and psychiatric intensive care units

Good

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

Each patient had their own en-suite bedroom, including a television set, and could personalise their room. Patients did not have keys to their bedrooms, but staff said that these could be provided on request. Patients had a secure place to store valuable possessions within the staff office.

Staff used a full range of rooms and equipment to support treatment and care including a quiet room, therapy room, activities room, and female lounge. The service had quiet areas and a room where patients could meet with visitors or make phone calls in private. Patients were able to keep their own mobile telephones and a ward telephone was available for patient use.

The service had an outside space that patients could access easily. At the time of the inspection, this area was supervised at all times due to scaffolding around the building.

Patients could make their own hot drinks and snacks including toast, cereal, yoghurts, and fresh fruit, without being dependent on staff, and we observed patients doing this. Patients told us that they were offered a variety of good quality food.

There was no patient computer available on the ward and no Wifi available. Patients were able to keep their own smart phones and staff said that they could use the upstairs office computer if needed, but this was a staff computer.

We observed that the ward manager had escalated some maintenance issues on Blake Ward to the hospital director, including problems with television sets on the ward (which were resolved), and complaints about the comfort of the mattresses on the beds (which was being looked into).

All patients we spoke with described a lack of sufficient activities to do during the day, and particularly at weekends. The ward manager had plans to increase the occupational therapy assistants' presence on the ward at weekends. However, with the current occupational therapist position unfilled on the ward, staff acknowledged that there were not enough activities happening for patients throughout the week. An occupational therapist was being recruited for the ward.

Activities recorded on the occupational therapy noticeboard included self-directed activities such as playing pool, and use of the garden, and organised groups including current affairs, walking, gentle exercise, baking, quizzes, art, poetry and karaoke. Staff reported that they attempted to facilitate these as far as possible, with some support from occupational therapy assistants, but it was not always possible due to other duties on the ward.

The ward manager advised that they were looking at ways of changing the layout of the ward, to make more use of the rooms available, including the possible addition of an occupational therapy kitchen on the ward.

Patients' engagement with the wider community

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

Acute wards for adults of working age and psychiatric intensive care units

Good

Staff helped patients to stay in contact with families and carers. Staff encouraged patients to develop and maintain relationships both in the service and the wider community. However, due to most patients being placed at a significant distance from their home, it was not always possible or helpful for them to be supported to access relevant local opportunities for education and work, other than by virtual means.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for some disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The service was able to provide leaflets in languages spoken by patients and interpreters/signers as needed.

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

Patients had access to spiritual, religious and cultural support with a multifaith room available for their use on the ward. Staff told us how they had supported patients to observe Ramadan, keeping food aside for them as needed, and had supported patients to observe Shabbat, with Halal and Kosher food easily available. One staff member said that they had intervened to ensure that a patient from a particular country, who had not been eating, was provided with cultural food which was more appealing to them.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The service displayed information about how to raise a concern on the ward and in the brochure for patients and carers.

Staff understood the policy on complaints and knew how to handle them. They acknowledged complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. Most recently the ward manager had identified a theme relating to staff communication with patients, and was arranging training for the whole staff team in this area. The managers protected patients who raised concerns or complaints from discrimination and harassment.

The service also used compliments to learn, celebrate success and improve the quality of care on the ward.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Acute wards for adults of working age and psychiatric intensive care units

Good

Good

Leadership

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

The newly appointed hospital director and interim clinical director visited the ward frequently and had good oversight of the service. The senior leadership team were experienced and had the knowledge and skills to undertake their roles. Leaders in the service were visible and accessible to staff and patients. Staff spoke highly of the senior leaders in the service and said that development opportunities were available for staff. For example, the new deputy manager on Blake Ward was promoted from one of the forensic wards and was being provided with management training.

Senior managers and the ward manager attended the acute service network meeting for the provider organisation on a quarterly basis.

Vision and strategy

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

The provider had a clear vision to make a real and lasting difference to patients' lives by putting people first, being supportive, acting with integrity, being positive and striving for excellence. The provider worked closely with NHS trusts and Clinical Commissioning Groups to support patients who had been placed away from their local area as best they could. They aimed to work collaboratively with discharge teams to ensure a smooth transition back into community services, or to an individual's home where possible.

Culture

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

Staff were positive about working at the hospital and support from the hospital director and new director of clinical services. They were very positive about the organisation and support provided by the ward manager and new deputy.

Staff were aware of the provider's whistleblowing policy and told us that they would speak up about any concerns they had. They noted that some staff preferred to remain as bank staff rather than become substantive members of the ward team.

Staff told us that they could get counselling within the organisation if needed and looked forward to the Christmas party provided for staff. A new staff breakfast club had been piloted, which was well attended.

Governance

Acute wards for adults of working age and psychiatric intensive care units

Good

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

The provider carried out its own benchmarking inspection in July 2021, producing an internal compliance report. Following this review, improvements were made to the management and control of restricted items, infection control procedures and safety protocols for visitors to the ward, and care planning. However, work was still awaited to improve the ventilation on Blake Ward, which could become excessively hot.

The ward had a permanent ward manager and deputy in place, and although it had significant staffing vacancies, the staffing situation had improved considerably in recent months. However, there was no ward administrator in place which impacted on the time available to staff and managers on the ward. The service was in the process of recruiting a new ward administrator.

The European Committee for the Prevention of Torture had recently visited Blake ward. They had raised concerns about occupational therapy and psychology support on the ward. Whilst a recent improvement had been made in psychology provision, there remained a vacancy for a ward occupational therapist.

Staff told us and we saw records indicating that staff received regular clinical and management supervision. However, there was room for improvement in the oversight of supervision provided, to ensure that no staff were being missed.

Hospital clinical governance meetings reviewed a wide range of quality and safety information, including ward community meeting minutes, infection control audits, incident reports and complaints. The minutes of the clinical governance meetings were stored on the staff intranet so that all staff could access and read them.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The hospital had a risk register which outlined the current highest risks in the service. These risks reflected those we found during the inspection and those reported by staff. Staff could submit items to the hospital's risk register through the ward manager or they could speak directly to senior managers. At the time of the inspection, highly rated risks included the roof repairs needed to Blake Ward and a lack of connection between the ward alarm system on Blake Ward and the forensic Wards. In the interim period before they would be fully resolved these risks were mitigated by an additional staff member working on Blake Ward, to manage the risk of scaffolding, and staff carrying radios to connect with staff on the forensic wards in the event of an emergency.

The provider undertook environment quality walks on a regular basis, which included looking at two patient bedrooms each time. On 7 September 2021 the findings included high standards of cleanliness, a tidy and welcoming environment. Improvements were noted in reposting the informal patients' rights poster by the exit, and in securing an oxygen cylinder to the clinic room wall. The need for improved ventilation on the ward was also noted. In addition, staff on the ward undertook daily walk arounds to check on the safety and quality of the environment.

We looked at health and safety systems on the ward including infection control checks, up to date portable appliances testing and first aid boxes being checked regularly. There was a major incident contingency plan in place for the ward.

Acute wards for adults of working age and psychiatric intensive care units

Good

Staff told us that previously when local mental health trusts had block purchased beds on the ward, they had little opportunity to choose not to admit patients whose needs they had concerns about managing. However, now they were able to make their own assessments and decide on suitability of any new admissions.

Information management

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

The provider used systems to collect data from the ward that was not over-burdensome for front line staff. Staff had access to the equipment and information technology needed to do their work. Staff said they had sufficient computers to carry out their roles. Information governance systems included confidentiality of patient records. All computer systems were assessed by individual usernames and passwords. The ward manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Staff made notifications to the relevant external bodies as needed. Staff sent notifications in a timely manner to the Care Quality Commission in relation to patients sustaining injuries, allegations of abuse and incidents reported to the police.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was provided.

Blake Ward was part of the provider's Acute mental health ward network. The ward had links with other services within the provider community including local psychiatric intensive care units, rehabilitation units and other specialist units. Staff had up-to-date information about other local providers, and services within the provider organisation.

Learning, continuous improvement and innovation

The hospital management team were committed to continuous improvement of the service. There was a focus on recruitment and retention and providing training for staff in patient care and communication skills.

Requires Improvement

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Requires Improvement

Safe and clean environment

The ward was safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed risk assessments of the ward environments, including ligature risk assessments. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Environmental risks such as potential ligature anchor points and blind spots were known by staff, who had strategies to safely manage these risks, such as the use of CCTV cameras covering blind spots and by conducting routine hourly observations.

All secure wards provided treatment to male patients only, so wards complied with guidance on same-sex accommodation.

During the last inspection in April 2018 we identified that there were not always enough personal emergency alarms for staff to wear, and that these were not always working correctly. At this inspection this had improved and there were always enough working personal alarms for staff to wear.

However, two emergency alarms in bedrooms on Coleridge ward were not working correctly. The alarms had been checked by staff and recorded as not working for a few weeks before the inspection. Staff had not taken action to escalate this to get the alarms fixed and working again. This posed a risk that staff or patients requiring immediate assistance in an emergency would not be able to call for help.

Maintenance, cleanliness and infection control

All wards were clean and well maintained. Cleaning records were kept up to date and infection control procedures, including hand washing, were followed by staff. There were clear policies for staff to follow during the Covid-19 pandemic. This included testing for all patients on admission and isolation for any patients showing symptoms of infection. All staff completed lateral flow tests two to three times per week.

Requires Improvement

Forensic inpatient or secure wards

Seclusion rooms

Two seclusion suites were situated on Coleridge ward, but were available for use by patients from any ward in the hospital if needed.

Theseclusion suites were safe and fit for their intended purpose. They complied with the requirements of seclusion facilities outlined in the Code of Practice: Mental Health Act 1983. For example, patients could access adjoining toilet and shower facilities, rooms were ventilated and let in natural light. Lighting and room temperature could easily be adjusted, and patients had sight of a clock and could communicate with staff via an intercom system. Staff could safely observe all areas of the seclusion suites and blind spots were covered by cameras.

Clinic room and equipment

A clinic rooms was located on each ward. They were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment and kept up to date records of this. All equipment was appropriately calibrated, with weekly clinical room checks recorded by the nurse in charge, and a pharmacist. A defibrillator and a crash bag including ligature cutters was readily available, and all medicines were safely stored and managed by staff.

Safe staffing

The service had a significant number of staff vacancies but had enough nursing and medical staff who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

During the last inspection in April 2018 we identified numerous staff vacancies, and that the service relied heavily on temporary staff. At this inspection, there were still numerous registered nurse and nursing assistant vacancies. Across the three secure wards hospital, 12.5 Whole Time Equivalent (WTE) registered nurse posts were vacant, out of a total of 22 WTE. Also, across the three secure wards, there were 13 WTE healthcare support worker posts vacant out of a total of 43 WTE posts.

Some staff and patients reported that Section 17 leave was sometimes cancelled and re-arranged due to staff shortages or over-reliance on temporary staff who were unfamiliar with patients. Some staff explained that temporary staff were more likely to cancel their shifts at short notice, which was particularly challenging. Some patients reported that they were frustrated with the fact that staff were unfamiliar to them and they could not develop therapeutic relationships in the way they would like to.

However, most vacant shifts were covered by either bank or agency staff, so the service provided the appropriate staffing cover to keep patients safe. The provider made efforts to use regular agency staff who received a full staff induction and training, the same as permanent staff, to promote good quality and consistency of practice. This helped keep patients safe from avoidable harm.

Ward managers were able to adjust staffing levels as needed, for example, to account for changes in case mix to ensure all patients required the appropriate level of nursing support to meet their needs.

Requires Improvement

Forensic inpatient or secure wards

A registered nurse was always available on each ward to support patients as needed. Coleridge ward was split across two floors. A staff member was permanently stationed on the communal upstairs bedroom corridor.

Leaders reported that there were ongoing challenges with staff retention and that turnover was high. Staff turnover was 27.8% during the 12 months before the inspection. Senior leaders reported that staff retention was an ongoing focus for improvement, but that this had been affected recently by staff leaving their posts because of factors related to the Covid-19 pandemic and the fact that lots had changes had been made to the way the service operated in recent years.

Senior staff explained that they were working to improve staff recruitment and retention, and this featured on the hospital risk register. The service was now working with six nursing agencies to help ensure shifts were safely covered by enough staff. Leaders were also working to recruit longstanding agency staff into permanent roles and had linked up with local universities to help recruit newly qualified staff.

During the 12-month period before our inspection staff sickness rates were 7.7%. Leaders reported that this rate was higher than in previous years because of the effect of the Covid-19 pandemic and the fact that many staff had needed to self-isolate at various points in the past year. Leaders supported staff who needed time off for ill health.

Medical staff

Medical cover consisted on one consultant psychiatrist for each of the three forensic wards. There were not currently any doctors working at different grades in the secure service.

The consultant psychiatrists from each of the three forensic wards and the neighbouring acute ward were part of an on-call rota. This ensured that a Consultant Psychiatrist was available on-call at all times out of hours and could attend promptly if needed.

Mandatory training

Staff had completed and were up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Over 75% of staff had completed all mandatory training courses. However, on Byron ward some courses how lower completion rates: 64% of staff had completed their training in Deprivation of Liberty Safeguards and 70% of staff had completed their breakaway training. Leaders reported that this was because some staff on Byron ward had recently started working at the service and would be completing this training soon. Agency staff were encouraged to undertake training in prevention and management of violence and aggression through the provider to ensure all staff were trained to the same standard.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.

Requires Improvement

Forensic inpatient or secure wards

Staff completed risk assessments for each patient when they were admitted. In most cases, these risk assessments were reviewed at regular intervals and when significant changes in risk had occurred, such as after incidents involving the patient.

Staff discussed changes to individual patient risk levels during daily shift handover meetings, and the overall risk score for each patient was displayed in each ward nursing office for staff to refer to with ease.

However, some contextual information was missing from some patient risk assessments. For example, on Keats ward we identified that one patient's violence and aggression risk score had been downgraded, despite them being involved in a recent incident of violence and aggression. Although some staff were able to explain why the risk score had been downgraded, the rationale was not recorded in the risk assessment and was difficult for other staff to follow. Another patient's overall risk score had been changed following an incident where they had been assaulted by another patient. Although details of the assault were recorded elsewhere in the patient care and treatment record, it was not clear within the risk assessment why their overall risk score had been changed.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. They identified and responded to any changes in risks to or risks posed by patients.

There was a clear list of prohibited items that were not allowed to be brought onto the wards for safety reasons. Staff followed the provider's policy when they needed to search patients or their bedrooms to keep them safe from harm. Staff noted what patients were wearing before going out on leave to aid their return if they didn't return to the service at the agreed time.

Staff completed routine observations of each ward environment to help ensure patients were safe from potential risks within the hospital. However, these observations were not always consistently recorded. On Keats ward staff did not always record the time that they had completed their environmental observations.

Staff did not always monitor patient's physical health to detect potential deterioration when they had received medicines by intramuscular rapid tranquilisation. We identified one case where a patient on Keats ward had been administered a dose of antipsychotic medicine by intramuscular injection. The patient had not been subject to regular physical health monitoring at 15-minute intervals immediately after this medicine was administered, despite them having a significant physical health condition that increased their risk of physical health deterioration.

Following the inspection, senior leaders reported that they had made plans to ensure all staff were aware of their responsibilities in relation to physical health monitoring and rapid tranquilisation. They also reported that they were developing a new physical health monitoring template for staff to use following instances of medicines being administered via rapid tranquilisation.

Use of restrictive interventions

The service had made limited progress with its reducing restrictive practice programme. This contrasted with similar services nationally that had been working to reduce restrictive interventions applied to patients for a considerable time. The project group had only recently met for the first time shortly before the inspection and were not yet analysing data related to interventions like restraint and rapid tranquilisation to identify themes or contextual factors that might increase the likelihood that patients might experience restrictive interventions.

Requires Improvement

Forensic inpatient or secure wards

Staff were not able to explain how the frequency of restrictive interventions such as restraint and seclusion had changed over time.

However, all staff were trained in de-escalation techniques and staff described how they aimed to de-escalate and avoid using restrictive interventions where possible. Incidents of restraint were appropriately recorded. This included details such as position, duration and which staff were present.

Seventy-eight episodes of restraint had been experienced by patients at the hospital during the 12 months before the inspection. None of these restraints were in the prone (face down) position.

Fifty-six episodes of seclusion had been experienced by patients at the hospital during the 12 months before the inspection. There had been 11 episodes of long-term segregation during the same timeframe. One patient was experiencing long term segregation at the time of the inspection whilst they waited for a bed to become available at a service that could more appropriately meet their needs. Staff were working hard to facilitate this discharge as soon as appropriate. Seclusion and long-term segregation reviews were completed in line with the requirements of the Code of Practice: Mental Health Act 1983.

There had been seven cases where patients had received medicines by rapid tranquilisation during the 12 months before the inspection. Staff had not always followed their responsibilities in relation to physical health monitoring of these patients to protect them from potentially significant physical health deterioration.

Safeguarding

Staff uderstood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff were trained in safeguarding and knew how to recognise reports of potential abuse and take action to keep patients safe. The process for making a safeguarding referral was clearly displayed for staff to follow.

Children rarely visited the hospital. A separate family room was available away from the main ward environments where staff could safely facilitate visits from children.

Staff access to essential information

Mostof the patient care and treatment records were stored electronically. These were available to all staff including temporary staff working on the wards.

Physical health monitoring observations were recorded on paper. Staff ensured these were securely stored and accessible to staff who needed them.

Medicines management

Staff followed good practice when managing medicines. Medicines were prescribed, stored and administered safely. Doctors reviewed patients' medicines regularly and worked closely with patients to ensure they understood their medicines and side effects, and to explore alternative medicines where appropriate.

Patient medicine records were completed accurately, and the necessary treatment authorisations were attached.

Requires Improvement

Forensic inpatient or secure wards

Staff reviewed the effects of medicines on each patient's physical health, especially where they were prescribed antipsychotic medicines. A physical health lead nurse worked across the hospital and helped ensure physical health was monitored in accordance with each patient's prescribed medicines.

Track record on safety

Nine incidents that had been reported across the hospital in the last 12 months met the provider's definition of a serious incident. Each of these had been reported appropriately and staff had reflected on them and learnt from them.

Reporting incidents and learning from when things go wrong

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

During the last inspection in April 2018 we identified that staff were not always able to discuss and reflect on what could be learnt from recent incidents. At this inspection this had improved. Staff now attended regular ward team meetings where learning from recent incidents was discussed. Lessons learnt bulletins were also sent to staff. For example, on Coleridge ward staff explained that a patient's care plan had been changed so nursing staff could better support them during mealtimes. This followed an incident where they had become distressed during a mealtime because of the way staff were trying to enforce their individual diet plan.

Staff knew how to identify and report incidents using the incident reporting system. They explained that senior leaders encouraged incident reporting as an opportunity to learn. Staff also understood their responsibilities under the Duty of Candour and being open and transparent with patients and relatives when things may have gone wrong.

Staff reported that they had attended debrief sessions following serious incidents. These were facilitated by psychologist colleagues.

Are Forensic inpatient or secure wards effective?

Good

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission. Physical health was then routinely reviewed throughout the duration of treatment. A physical health lead nurse supported ward staff to meet the physical health needs of patients.

Staff developed patient care plans in collaboration with patients. These were regularly updated, and it was evident that patients had contributed their views and opinions to these plans. They were divided into specific sections 'keeping safe,' 'keeping healthy,' 'keeping connected', and 'keeping well.'

Requires Improvement

Forensic inpatient or secure wards

Most care plans were updated regularly. However, we identified that one patient's significant physical health condition was not detailed in their care plan. Although staff spoke to us about how they supported the patient with their physical health condition, this posed a risk that new or temporary staff less familiar with the patient may not be able to identify the support the patient required. We escalated this during the inspection and staff addressed it.

Best practice in treatment and care

A range of care and treatment interventions were available to patients. Occupational therapists and psychologists worked across the wards. A social worker also worked across the hospital. However, each professional discipline had vacant posts at the time of the inspection. Staff working in them explained that they had to prioritise which patients needed their support the most. Psychology staff ran group sessions for patients to help ensure that those not able to access one-to-one support had some access to psychological interventions. Occupational therapy (OT) staff spoke about the need to embed a more robust internal OT referrals system so they could better prioritise one-to-one support for patients who needed it most.

Staff supported patients to lead healthy lifestyles. They promoted diet and exercise and provided patients with smoking cessation advice and tools where appropriate. This included introducing some patients to e-cigarettes and encouraging them to reduce their smoking in a manageable way.

Patients had personal goals, which often included plans to attend activities that would be beneficial to them. Staff monitored whether patients were attending and engaging with groups they agreed to attend. Other than this monitoring, no formal outcome measures were used to demonstrate the effectiveness of occupational therapy or psychology interventions.

Patients were involved in decisions about their care and treatment. They were encouraged to attend ward rounds and participate in discussions about their care and treatment. Most patients could clearly explain their treatments including prescribed medicines to us. Staff made efforts to offer patients choice in their treatments where appropriate. For example, one patient on Coleridge ward had worked closely with the ward consultant psychiatrist to identify a more suitable long-term antipsychotic medicine for them. They had been prescribed an existing medicine for several years and were not happy with its side effects and were happy to have been given the opportunity to explore other treatment options whilst using the service.

During the last inspection in April 2018 we identified that patient's physical health was not robustly monitored by staff in a systematic way. At this inspection this had improved. Routine monitoring of all patients' physical health was carried out every week as a minimum. A physical health lead nurse ensured that patients ongoing physical health, long term physical health conditions and required physical health monitoring for those prescribed antipsychotic medicines took place.

Skilled staff to deliver care

Vacancies existed within the allied health professional staff group. Social workers, Occupational Therapists and Psychology staff all told us that they had to carefully prioritise patients who needed individual support whilst roles were being recruited to. Most of these staff were currently working across more than one ward.

Requires Improvement

Forensic inpatient or secure wards

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. They also received a comprehensive induction to the service at the start of their employment. Staff received regular supervision and found these sessions supportive. Supervision completion across the service was consistently above 90%. Leaders described how they supported staff through periods of poor performance by setting achievable goals and objectives.

Multidisciplinary and interagency teamwork

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

Staff from all professional disciplines within the hospital attended multidisciplinary meetings on each ward. Staff reported that they contributed as equal team members at these meetings and their views were valued by others.

The service was a member of the North London Forensic Consortium. This is a group of providers in the local area who provide services within the forensic care pathway. Doctors reported that membership of this group enabled them to form close relationships with case managers. They could get in touch with colleagues in community teams with ease. Doctors could also request pathway and care reviews by colleagues within the local system and these were arranged with ease. This included external reviews of long-term segregation and some cases of seclusion, where peers working in other organisations contributed to clinical discussions.

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

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

Staff had a good understanding of the MHA, its code of practice and how it applied to their day to day work with patients and staff were up to date with training in the MHA.

A MHA administrator was based on site and staff reported that they could have any queries relating to the application of the MHA answered with ease. During the last inspection in April 2018 patients were not always actively supported by staff to contact the independent mental health advocate. At this inspection details of the independent mental health advocate were clearly displayed and staff supported patients to contact the advocate if they wanted to. Staff regularly met with patients to discuss their understanding of their detention under the MHA and what this meant in terms of potential leave entitlement under Section 17. Patients generally had a very good understanding of their rights as a detained patient and about their personal leave arrangements. However, many staff and patients expressed frustration that patients leave often had to be changed or re-scheduled at short notice due to staffing pressures. Regular audits of how the MHA was being applied were completed internally and actions from these audits were escalated and addressed by staff.

Good practice in applying the Mental Capacity Act

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

Requires Improvement

Forensic inpatient or secure wards

Staff had a good understanding of the MCA and understood its five principles. They were up to date with their training on the MCA.

There was a clear policy on Mental Capacity Act which staff knew how to access, and they also knew where to get accurate advice on the Mental Capacity Act within the provider organisation.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We observed mental capacity assessments recorded for patients where there was any doubt about their ability to consent to treatment.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Are Forensic inpatient or secure wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

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

We observed that staff interacted well with patients and gave them the support they needed. We spoke with 13 patients being treated on the forensic wards. Most of these patients reported that they had positive relationships with staff and felt well supported by them. However, some patients reported that they did not always feel well supported by temporary staff who they were less familiar with.

Staff felt able to raise concerns they had about disrespectful or discriminatory behaviours that were aimed at them. Staff also maintained the confidentiality of information about patients by storing all records securely and displaying patient information in secure staff only areas away from general view.

Involvement in care

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

Involvement of patients

Staff took time to introduce patients to the ward when they were first admitted. Each patient had a named nurse. Although numerous staff vacancies existed, patients reported that one to one time with their named nurse was prioritised and they could routinely meet with them to discuss their care and treatment.

Requires Improvement

Forensic inpatient or secure wards

Patients had a good understanding of their care and treatment. This included details about their medicines and detention status under the MHA. We observed a ward round where patients were empowered by staff to take part in discussions about alternative medicines that could be used to manage their mental health condition. Patients were also involved in developing their care plans and were offered their own copies.

During the last inspection April 2018 patients did not know how to access support from an advocate. At this inspection this had improved, and most patients stated that they could contact an advocate easily if needed. They also explained how the independent mental health advocate had been very supportive during tribunals.

Patients were encouraged to provide feedback about the service by staff. Patients provided feedback at weekly ward community meetings. The hospital complaints manager also held feedback clinics on each ward where they discussed issues with patients face to face on the wards, meaning that some issues could be resolved promptly. Some patients had also completed feedback questionnaires about their experience using the service.

Involvement of families and carers

Staff supported, informed and involved families or carers and encouraged families to give feedback on the service. Relatives and carers could join ward round or care programme approach meetings by telephone if patients consented to them being involved.

Patients could see visitors in a dedicated visiting room away from the main ward environments. At the time of the inspection, relatives were also encouraged to meet with patients in the outside communal areas of the hospital to help minimise the risk of Covid-19 infection. Patients reported that staff generally supported them to keep in touch with loved ones using videocalls or by using telephone calls.

Senior staff reported that they had plans to improve carer involvement soon by re-launching carers support groups on a virtual meeting platform.

Are Forensic inpatient or secure wards responsive?

Requires Improvement

Access and discharge

Bed management

Bed occupancies across the forensic service had decreased during the Covid-19 pandemic. Senior leaders reported that this was a trend that other similar services in the region had also reported but that there was no known cause as to why fewer referrals for forensic inpatient services were being made. This meant that there were unoccupied bedrooms on each of the three wards, and beds were available for local people as needed.

Beds were always kept for patients to return to if they were away on extended leave. Patients did not move between wards unless this had been agreed for clinical reasons.

Discharge and transfers of care

Requires Improvement

Forensic inpatient or secure wards

Patients very rarely experienced delays to their discharge from the service. During the 12 months before the inspection, five patients experienced a delay to their transfer of care to another service.

The delayed discharges that had occurred were generally due to significant challenges in identifying suitable accommodation for patients who were being discharged from hospital to the community. There had been no delayed discharges on Coleridge ward. This was because this was a medium secure ward and patients were normally transferred to one of the low secure wards from Coleridge ward.

The service was a member of the North London Forensic Consortium. This was an overarching group of local providers led by the local NHS mental health trust. The providers worked closely together to ensure patients were referred to the most appropriate ward in the local area to meet their needs. Doctors reported that the consortium enabled them to work closely with case managers, who communicated with community mental health teams to help ensure discharges were well planned and timely, and always happened at an appropriate time of day.

Facilities that promote comfort, dignity and privacy

During the last inspection in April 2018 we identified that the ward environments on the three secure wards needed to be improved. This featured on the hospital risk register at that time. During this inspection, the need for improvements to the ward environments continued to feature as the second highest risk on the hospital risk register. The wards continued to be sterile in nature and minimal effort had been made to improve the therapeutic nature of the ward environments or make them feel more welcoming. For example, there were very few displays or artworks and no sensory equipment. Although most of the walls had recently been painted there was little evidence to suggest that improvements had been made to the therapeutic nature of the ward environments since the last inspection.

Although the therapeutic nature of the ward environments needed to be improved, the facilities did promote patient's dignity and privacy. Each patient had their own bedroom, could make telephone calls in private and had access to outside space. Some patients also reported that they thought the food was of good quality.

Patients' engagement with the wider community

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

Patients were encouraged to develop their workplace skills and social tolerance by taking part in hospital-based jobs. This included working at the hospital shop or within the patient library. A patient on Byron ward had recently been supported by staff to carry out a voluntary role at a local charity shop.

Maths and English tutors attended the service to provide one to one tuition to patients who wanted to expand their knowledge in these areas to improve their future employment prospects. A horticulturalist also worked at the service and supported patients to build their skills in gardening.

Patients who were granted leave under Section 17 of the MHA were encouraged to use local amenities including shops, a leisure centre and community library.

Meeting the needs of all people who use the service

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

Requires Improvement

Forensic inpatient or secure wards

Adjustments were made for patients with some disabilities. Staff carefully considered each referral to the service on an individual basis to ensure people's needs relating to disability could safely be met. Interpreters and signers could be accessed to support patients to understand information relating to their care and treatment. Any leaflets, such as leaflets about how to complain, could be translated into another language if needed. A telephone interpreting service could be accessed if an interpreter was needed at short notice. Staff supported patients to observe their spiritual and religious needs. For example, staff explained how they had identified specific religious ministers, such as an Iman, to attend the service and meet with patients. Some patients were escorted by staff to worship at local churches. A multifaith room was available on site and contained resources such as religious texts and a prayer mat. Staff worked hard to ensure patients dietary requirements were met, particularly in relation to their cultural or religious needs. Specific requests for foods or menu alterations could be made with ease.

Listening to and learning from concerns and complaints

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

Sixty-three complaints had been received during the 12 months before the inspection. Six of these had been upheld and none had been referred to or upheld by the parliamentary health service ombudsman.

Information about how to complain was clearly displayed on each ward, including in easy-read format and staff proactively supported patients to make complaints. The complaints manager had recently implemented patient drop-in clinics on each ward. Patients appreciated the opportunity to have their complaints resolved informally and promptly using the drop-in. Staff reported that the successful introduction of these patient drop ins had reduced the number of complaints that were made formally. We identified that changes were made following complaint investigations to improve the quality of the service. For example, ward managers now ensured that patient's primary nurses were on shift when patients were first admitted to the wards. This was because the service made a commitment to patients being introduced to their primary nurse when they first arrived at the service, but one patient had complained that their primary nurse was not working on the day they were admitted and they had to wait to meet them.

Are Forensic inpatient or secure wards well-led?

Good

Leadership

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

The hospital director and interim director of clinical services were visible across the hospital and known to staff and patients.

The ward manager post on Byron ward was vacant at the time of the inspection. The director of clinical services, who was the existing ward manager, continued to be responsible for overseeing the ward daily whilst an acting ward manager was being recruited. The ward manager on Coleridge ward was on an indefinite leave of absence during the inspection. The leave of absence started a few days before the inspection and was unexpected. Senior leaders were still

considering how this post would be filled in the meantime, and they ensured they were present on the ward each day to support staff. Leadership development opportunities including leadership training and shadowing opportunities were available to staff. The senior leaders had worked within the provider organisation for some time and had been supported with their own leadership development by the provider.

Vision and strategy

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

The provider had a clear vision to make a real and lasting difference to patients' lives by putting people first, being supportive, acting with integrity, being positive and striving for excellence.

Staff knew about the providers values and demonstrated these in their day to day work. Staff could explain how they were working to deliver high quality care within the budgets available, and how they worked closely with other organisations through the North London Forensic Collaborative to act in the best interests of patients in line with the provider values.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity and provided opportunities for development and career progression. They told us that they could raise any concerns without fear.

Staff were positive and proud about working for the provider and were well supported by their colleagues. Staff reported that leaders at the service were approachable and supportive of them. Leaders encouraged staff to provide feedback about their experiences and staff did not feel afraid to speak up if they had concerns.

Managers explained how they had worked hard to support staff whose performance needed to be improved, by using achievable targets and objectives to drive up performance.

Some staff reported that the provider should consider staff pay to help secure permanent staff to fill vacancies rather than bank staff, and to improve staff retention.

Governance

The provider needed to strengthen some of its local governance processes because some of the issues identified during the inspection had not been systematically identified internally by the provider. For example, some patient risk assessments on Keats ward lacked the necessary rationale as to why risk scores had been changed by staff. Two of the bedroom emergency alarms on Coleridge ward had been recorded as not being in working order by staff but no follow up action had been taken. There were inconsistencies in the way general observations were recorded by staff on Keats ward. None of these issues had been identified by any assurance process and senior staff were unaware of these issues before we escalated them during the inspection. A range of quality and safety information was reviewed at clinical governance meetings. This included issues raised at ward community meetings, actions that had arisen from audits including infection prevention and control, an overview of recent incidents and what could be learnt from them, and whether any actions had been identified from recent complaints. The minutes of the clinical governance meetings were stored on the staff intranet so that all staff could access them. Ward managers also had access to key performance information to help them effectively manage their staff teams. This included individual staff training and supervision completion.

Requires Improvement

Forensic inpatient or secure wards

Management of risk, issues and performance

A hospital wide risk register was maintained and reviewed by staff at the monthly clinical governance meeting. Leaders were familiar with the top risks and spoke about how they were working to mitigate these. For example, the main fire alarm panel for the hospital was due for a replacement. It had recently been repaired following a fault and a thorough check to ensure the system continued to work effectively was made every week. A replacement was due to be installed soon. The therapeutic quality of the ward environments and seclusion suites were flagging as top risks on the risk register, and works were planned soon to improve these so that they were more conducive to patient recovery.

Information management

Systems to collect data from wards and directorates were not over-burdensome for frontline staff. Staff had access to the equipment and technology needed to do their work. However, some staff reported that they were frustrated that they sometimes needed to type up written notes in the nursing office after having met with patients for one-to-one sessions due to a lack of portable technology.

Information systems protected the confidentiality of patient records. All computer systems were assessed by individual usernames and passwords. Staff made notifications to the relevant external bodies as needed. Staff sent notifications in a timely manner to the Care Quality Commission in relation to patients sustaining injuries, allegations of abuse and incidents reported to the police.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was provided.

The service was a member of the North London Forensic Collaborative, which was hosted by the local NHS mental health trust. This helped staff link up with colleagues working at other local providers to help facilitate smooth transfers of care.

Staff and patients received updates about the work of the provider via a regular bulletin. Leaders were considering how to strengthen carer involvement and how to safely re-launch carer support meetings.

Senior leaders, including the regional director, were physically present across the hospital and staff and patients knew who these individuals were and felt able to speak with them about any issues they had. The complaints manager met face-to-face with patients during informal ward-based feedback forums.

Learning, continuous improvement and innovation

A new commitment to service improvement and innovation was being driven by leaders. This was because recent priorities were to get some of the key elements of the service right. This included considering how to achieve a more stable workforce and on ensuring staff followed the necessary infection, prevention and control procedures in relation to the Covid-19 pandemic.

A new quality improvement project focussing on reducing restrictive interventions had recently begun. There had also been a recent focus on embedding reflective practice for staff. This involved using case studies for staff to reflect on their approach to appropriately managing patients exhibiting distressed behaviours.

Requires Improvement

Forensic inpatient or secure wards

There were no examples of staff being involved in research projects at the time of the inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients using the acute service did not have access to the appropriate treatment to meet their needs because they did not receive input from an occupational therapist and there were not enough therapeutic activities for patients to engage with.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The therapeutic nature of the forensic ward environments needed to be improved.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not always complete the necessary physical health monitoring of patients who received medicines by intramuscular rapid tranquilisation, to protect patients from significant physical health deterioration. Staff did not always identify and escalate instances of emergency alarms not working in a timely manner to help ensure staff and patients could always call for help in an emergency.