Hertfordshire Partnership University NHS Foundation Trust

Forensic inpatient or secure wards

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Forensic inpatient or secure wards

Inspected but not rated

We carried out an unannounced focused inspection of Warren Court because:

We received information giving us concerns about the safety and quality of the services at Warren Court from stakeholders, members of the public and staff who worked at the service. Concerns related to the safety of patients, the management of safeguarding, the use of restrictive practice, staffing levels and the levels of assaults against patients and staff.

As this inspection was focused, we only visited Warren Court and did not look at all key lines of enquiry.

Warren Court is part of the Eric Shepherd Unit and is a service for people with a learning disability who require specialist or forensic healthcare. The service provides medium secure assessment and treatment services for men with learning disabilities, additional mental health needs and a history of offending behaviour.

The service's admission criteria included males aged between 18 and 65 years with a learning disability with a history of offending behaviours and where their mental state required conditions of medium security. All admissions were under the Mental Health Act. Warren Court was divided in to five houses. House 1 to 4 had five beds and house 5 had 10 beds and was the assessment and treatment house where patients were initially admitted. However, at the time of our inspection, managers had decided to just use five beds on house 5, due to the level of acuity. Newly admitted patients continued to be assessed prior to admission to determine the most appropriate house for admission and in consideration of their individual need.

We did not rate this service at this inspection.

We found:

- The service did not ensure that all seclusion records were completed in accordance with the Mental Health Act Code of Practice. We found gaps in several sections in one record relating to care and health needs. We also reviewed medical reviews for episodes of seclusion which lacked detail in some records.
- Patients we spoke with told us they did not always feel safe in the service due to the level of physical assaults between patients. Due to high levels of acuity, and to support safeguarding plans, patients were often moved between the houses, which they found unsettling. Staff did not ensure patients had access to regular patient forum meetings.
- The service did not ensure duty rotas accurately reflected movement of staff across the service and observation allocation sheets were not always fully completed.
- The service could not demonstrate that staff were in receipt of specialist training to support them in their roles and team meetings did not regularly take place.
- Staff morale within the service was variable. Some staff described low morale due specifically to increased acuity, incidents of assaults on staff and difficulties with maintaining staffing levels. Some staff did not feel that senior managers were visible, or that they could raise concerns without fear of reprisal.

Our findings

However:

- The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and 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. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received mandatory training, supervision and appraisal.
- 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.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

How we carried out the inspection

During the inspection visit, the inspection team:

- visited all houses at Warren Court, looked at the quality of the house environments and observed how staff were caring for patients;
- spoke with five patients and six carers or family members of patients who were using the service. Interviews with patients and carers were completed by telephone;
- spoke with 15 staff members; including managers, doctors, registered and non registered staff;
- attended and observed one care programme approach meeting and one risk assessment meeting;
- looked at seven care and treatment records of patients.
- reviewed the seclusion and long-term segregation records for one patient.

What people who use the service say

We spoke with five patients. Some patients said they felt unsafe when there were incidents of aggression between patients and were not happy about being moved between houses when this occurred. All patients we spoke to were positive about the staff who they said were kind and supported them well. Patients said if there were things they were unhappy about they were able to raise these with the service. However, they did not feel their concerns were always acted upon in a timely way. Overall, patients wanted increased opportunities to access fresh air and had fed this back to managers.

Patients did not have access to regular patient forum meetings. We were concerned that patients did not have significant opportunities to share their collective views around the running of the service, or the opportunity to suggest improvements or receive feedback. Patients said they spoke with advocacy staff if they needed to.

Our findings

We spoke with six relatives of patients. Relatives spoke positively about the hospital and the quality of the care that their relative received. Relatives and carers felt they were kept informed of and involved in the care received by their family member at the service. The majority of relatives felt that the needs of their family members were being met. The majority of relatives and carers were aware of how to complain and examples were given where complaints had been made and acted upon.

Is the service safe?

Inspected but not rated

Safe and clean care environments

All wards were 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 wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards.

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

Staff had completed ligature audits for all areas of Warren Court. Ligature audits contained photographs of the identified risks and how some these might be used to self-harm. Mitigation was included within the audit, including staff training, individualised risk assessments, and environmental assessment via ward walk arounds. The audits contained guidance for staff relating to areas of highest risk and sharing of learning from previous incidents, for example, risk posed by internal sliding windows and anti-barricade doors. The service had included risks from sliding windows and anti-barricade doors on their local risk register with management plans in place.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. The service ensured the hospital was clean. Staff completed a joint cleaning audit on a monthly basis, which included a percentage score against a number of metrics. The average compliance score was 97% in August 2021 and 96% in September 2021.

Staff followed infection control policy, including handwashing. The service completed a weekly infection prevention and control walk around audit across the hospital. For each audit an action plan was completed for any failings identified, which recorded actions taken to rectify the concerns. Staff also completed a monthly hand hygiene audit tool, with a requirement for all staff to be assessed for hand hygiene compliance on an annual basis. Additional audits completed included mattress audits, personal protective equipment compliance and quarterly environmental audits. The service was compliant with national guidance related to the management of Covid-19.

Our findings

The service received an overall Patient Led Assessment of the Core Environment score of 97% in the 2019 survey, against a national average of 91%. Findings from the latest Patient Led Assessment of the Core Environment-Lite assessment, dated August 2021 recorded a final impression of 'very confident' for all houses except house five which received a final impression of 'confident' due to building works at the time of the assessment. The service had an action plan in place to address any issues which was updated upon completion of actions.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. A new seclusion and long term segregation area was under construction at the time of the inspection but was seen to be spacious and to meet the Mental Health Act Code of Practice guidelines.

Safe staffing

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

Nursing staff

The service held daily safe care calls, including all the Hertfordshire located inpatient units across the learning disability and forensic strategic business unit. Staff were reallocated if there were any late shortages in staffing or increased acuity reported requiring additional staffing. Out of hours clinical leads contacted all units and helped to reallocate staff as/ if required.

At the time of the inspection the hospital was not fully occupied. However, the service had aimed to continue to provide the same level of staffing (13 staff) across the hospital, to provide additional support during a period of high acuity. However, the service's plan to ensure that 13 staff were rostered on duty was not always achieved. Between July and September 2021 there were a total of 74 healthcare support worker shifts and 56 registered nurse shifts unfilled. However, between July and September 2021 there were no shifts that were not filled to the required staff to patient ratio of 12 staff across the site. Team leaders supported the wards when required to ensure safe staffing was maintained.

The service did not keep records when staff were moved across the site to support other houses. We reviewed duty rotas and staff observation allocation sheets from 15 September to 29 September 2021. We found numerous examples where staff were allocated to patient observations on House 5, but these staff did not appear on the duty rota for that day. No reference is made on the allocation sheet as to where these additional staff had been sourced, or whether these staff were other members of the MDT. Staff did not complete the observation allocation sheets fully. For example, night staff were not consistently included in the examples we reviewed and staff allocations to general and intermittent observations were not always completed. We were concerned the service would have difficulty in identifying these staff allocated to specific observation should this be required. We were also concerned that, where staff were not appearing on the duty rota for House 5, these staff may have been moved across the different houses on site; meaning that other areas were potentially working with fewer staff than required.

Staff used the term lone working to describe a period where a staff member had worked in a house on their own. The service had a contingency plan in place to mitigate any unfilled shifts on houses 1-4. The service's contingency plan used staff from other houses to take hourly turns to cover the house or a team leader to support the house with staffing. Staff reported this as an incident if the contingency plan was not achieved. The service reported that staff did not work on their own or with less than three staff in House 5. The service had reported two incidents of lone working between July 2021 and September 2021. These related to staff cancelling shifts at short notice and an incident where a staff member had to work on another ward due to the level of risk posed to them from a patient.

Our findings

Minutes from the Hertfordshire secure joint patient safety & quality and risk meeting in July 2021, recorded that there was a patient safety concern raised about the staffing levels at Warren Court. This was due to last minute cancellations of bank shifts. Managers considered whether agency staff should be used to back fill any shortfalls in staffing, however, as Warren Court is a speciality unit, there was a preference to using bank staff, familiar with the patients.

The service had six registered nurse vacancies and four unregistered staff vacancies. Three of the registered nurse posts and three unregistered staff posts had been filled. Staff were due to start employment once all recruitment checks were completed.

The service filled 930 shifts with bank unregistered staff and 336 shifts were filled by bank registered nurses between July and September 2021.

Managers made sure all bank staff had a full induction and understood the service before starting their shift.

The service had increasing turnover rates. The service had three staff leavers between July and September 2021 with a rate of 0.95% in July 2021 increasing to 2.37% in September 2021.

Managers supported staff who needed time off for ill health.

Levels of sickness were increasing. Sickness levels were 7% with 13 staff on sick leave during July 2021. Staff on sick leave during August 2021 was 9.5% with 19 staff on sick leave. Sickness levels had increased by 2.65% between July and August 2021.

The ward manager could adjust staffing levels according to the needs of the patients.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The service's overall compliance with mandatory training was 91%. Compliance for moving and handling was 62% but managers were booking staff to complete this training in September 2021.

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.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the trust's restrictive interventions reduction programme.

Our findings

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Staff used a recognised risk assessment tool. Staff completed the Historical Clinical risk Management- 20 (HCR-20) tool to assess and manage violence and risk. We saw this was regularly reviewed and updated.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff documented and updated risks of patients in detail at every ward review meeting and provided an updated summary in the risk assessment records to ensure staff were aware of any new risks posed by patients. Staff documented early warning signs of patients so that staff were aware of the triggers that led to challenging behaviours by patients.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff were allocated to remain in the upstairs corridors to ensure they observed patients in accordance with the observations they were prescribed.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff participated in the trust's restrictive interventions reduction programme, which met best practice standards.

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.

The service reported 19 reported incidents with the use of restraint, relating to seven service users, From 1st July to 27th September 2021. None of these incidents were in the prone position. Seven incidents related to one patient (37%). Fourteen incidents occurred on House 5 (74%).

There had been no individual service users in Long Term Segregation (LTS) during the period of 1st July 2021 – 27th September 2021.

Staff followed NICE guidance when using rapid tranquilisation.

We found gaps in seclusion records. For example, there was no clear exit plan and no evidence that family or carers were informed of seclusion being implemented in one record. We also found the section on the seclusion care plan to record the patient's mental health state, physical health needs and diet and fluid intake and the post seclusion care plan were blank. The service updated these records following our visit.

We found the medical reviews for episodes of seclusion lacked detail in some records.

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.

Our findings

Between 3 September and 29 September, the service raised 17 safeguarding's. Of these, seven were categorised as physical, five psychological, two organisational, two sexual and one neglect or act of omission. All safeguarding concerns were reported within one day of the incident recorded. Nine safeguarding concerns were reported for House 5, four reported for House 1, two reported for House 3 and two reported for House 4. Four safeguarding plans required a patient to be moved to a different house. Staff used a safeguarding list to manage risks between patients so that they were aware of any risks posed to and by patients. Staff referred to the list when placing patients in houses and when patients used the courtyard for fresh air. Patients were moved between houses if there were any safeguarding risks to individuals.

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

Staff were kept up-to-date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

We did not review all aspects of medicines management, but have reported on rapid tranquilisation due to concerns raised about the management and use of this intervention.

The service completed an audit of all intra-muscular rapid tranquilisation administration by scrutinising 25 medication prescription charts between 1st August 2021 to 14th September 2021. There were four episodes of rapid tranquilisation administrations and 6 episodes of Clopixol Acuphase administration. Clopixol Acuphase injection is used for the initial treatment of acute episodes of mental disorders. It is also used to treat mania (a mental condition characterised by episodes of overactivity, elation or irritability) and used in case of worsening of chronic mental conditions.

The number of reported violence and aggression incidents during 1st August and 31st August 2021 was 81 and was 34 between 1st and 14th September 2021. In consideration of the number of reported violence and aggression incidents, the proportion of patients requiring rapid tranquilisation and intra-muscular Clopixol Acuphase, (medicines to manage agitation and aggression) was minimal. The doses prescribed were within prescribing limits and there was evidence of consideration made to use oral medication and other de-escalation techniques. Physical health monitoring was completed.

Our findings

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed 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.

The service provided two examples of serious incidents dated February and March 2021.

The service provided evidence of learning from serious incidents, including a one-page document detailing the incident, actions taken and learning to be shared with teams.

The service reported 12 incidents resulting in injury to staff between April and September 2021. Of these, three incidents were RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reportable. All three incidents related to physical assault to staff by one patient between July and September 2021.

There were 31 reported service user on service user assaults recorded from 1st April 20201 to 28th September 2021. Staff reported 28 of these incidents to safeguarding. Thirteen of the 31 incidents led to no harm, 16 incidents led to low harm and two incidents led to moderate harm.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy.

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

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

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

There was evidence that changes had been made as a result of feedback from incidents. Managers provided staff with learning points from two serious incidents. Learning points included ensuring management plans were in place to manage risks, documentation was completed ensuring all risks and incidents were recorded and immediate support was to be made available to staff following serious incidents. Further learning points included considering if changes were required to patient pathways and a review of issues with the therapeutic relationship between patients and staff to ensure improvements were achieved. Formulating positive behavioural support plans and risk management plans to manage on going challenging behaviour and providing specialist training to staff were also identified.

Our findings

Is the service effective?

Inspected but not rated

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. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All 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.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery-orientated.

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 used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used the Health of the Nation Outcome Scale-Secure to assess patients' outcomes.

Staff used technology to support patients. Staff supported patients with remaining in contact with their families virtually.

Our findings

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank staff. The service told us they provided staff with specialist training for their role. However, the service were not able to provide any data on compliance levels of specialist training completed by staff. The trust said they were taking action to ensure this would be recorded by the learning and development team and in individual training records.

Managers 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. The service had ensured all staff had received an annual personal development plan and at the end of August their compliance was at 100%.

Managers supported staff through regular, constructive clinical supervision of their work. The trust's supervision policy states that supervision should usually take place at a frequency of once every 4-6 weeks with a maximum interval of 8 weeks. Supervision compliance for Warren Court was 98% in July 2021, 97% in August and 100% in September 2021. This data is based on a maximum interval of eight weeks.

The service did not ensure all staff had access to regular monthly team meetings. Between July and September 2021, only staff on house 1 had access to a meeting each month.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Multi-disciplinary 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(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

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

Is the service caring?

Inspected but not rated

Our findings

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. However, patients did not feel safe due to the level of aggression between patients.

All patients we spoke with said they did not feel safe due to the level of physical assaults between patients. The service moved patients between houses as part of their safeguarding management plans. However, the majority of patients we spoke with said they were not happy about having to be moved between houses. We fed this back to the service who told us they would work on improving the way they managed safeguarding risks by supporting patients to work through their conflicts rather than moving patients to other houses in the first instance.

Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly.

Staff 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.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment. They ensured that patients had easy access to independent advocates but did not ensure patients had regular access to patient forum meetings.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments.

Patients were supported to co-produce their individual care plans and to review their progress by completing the trust's 'My Shared Pathway' document.

Staff worked collaboratively with patients to co-produce grab sheet positive behaviour support plans with patients.

Staff did not ensure patients had access to regular patient forum meetings. House 4 had the most recorded meetings, having six meetings from July to September, whilst House 1 and 2 had only one. We were concerned that patients did not have significant access to forum meetings to share their collective views around the running of the service, or the opportunity to suggest improvements or receive feedback.

Our findings

Staff reviewed individualised activity timetables with patients every 12 weeks which included goal setting by patients for the sessions identified.

Staff could create specific learning disability care plans which were co-produced with patients and included the function to add in pictures, where required.

Patients were offered the opportunity to complete an easy read advanced decision document for disturbed behaviour which detailed how they wished to be treated during these times.

The service had a risk and safety group where risk assessments were discussed with patients. Patients were offered the opportunity to complete their own staying safe care plan.

The service had a recovery college where courses were co-produced by patients.

The service was due to commence equine therapy for patients at the service. This was suggested by a patient who had previously used the therapy at a different service.

Staff made sure patients could access advocacy services. The service used the service People of Hertfordshire want Equal Rights (POHWER). Reports of the types of support provided to patients by POHWER, showed a range of supportive measures were available.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

The trust completed an audit in January 2021 which reviewed the service against the Carer Support and Involvement Toolkit (NHS England). An action plan was produced for the areas of improvement identified. One area was to provide training to staff on the values, rights and needs of carers which the trust was restarting in September 2021.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles. However, some staff told us managers were not always visible.

Culture

Staff did not consistently report feeling supported or valued and some staff said they could not raise any concerns without fear or reprisals.

Our findings

The majority of staff we spoke with did not feel supported or listened to by senior managers and some did not feel supported by their immediate line managers. Staff expressed concerns relating to staffing levels and 'lone- working'. We spoke to 11 staff and some staff told us that they had been left to 'lone work' on Houses 1-4 and said they felt anxious that recent action taken by management to increase staffing levels would not be sustained and was a short term measure. Staff felt that they did not have enough staff to cover shifts. Staffing levels was an issue identified in the staff survey in 2020 where just 29% of staff said they had 'enough staff at my organisation to complete my job properly'. The service's staff survey action plan, where staffing levels was an area identified as an action, referred to 'minimising staff working on their own'. The service were taking action to review staffing across the site and to ensure staff were not left without support across the service.

Staff did not feel managers were visible and felt that if they did raise concerns these were not listened to. The staff survey completed in 2020 showed that just 29% of staff felt that senior managers acted on staff feedback.

Staff expressed concern about the placement of one patient at the service and felt that they were unable to meet the their needs as they were inappropriately placed and did not meet the criteria for treatment at the service.

Some staff said they were fearful to share their views due to reprisals.

Staff said that the high number of incidents of assaults and accusations against staff led to high levels of sickness and a low morale amongst staff. Some staff said they did not feel confident in managing challenging situations as they felt their actions could be questioned by managers. Some staff said they did not feel safe working at the service due to the staffing levels and the levels of aggression from patients towards staff. The service reported 12 incidents resulting in injury to staff between April and September 2021. Of these, three incidents were RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reportable. All three incidents related to physical assault to staff by one patient between July and September 2021.

Staff who contacted the Care Quality Commission before the inspection raised concerns about the service's use of restrictive practices and told us there was a high use of rapid tranquilisation being used to manage challenging behaviours, that seclusions were used frequently and that some medical seclusion reviews were not being completed. However, during the inspection the majority of staff we spoke with, felt that restrictive practices were used appropriately and did not raise concerns about any colleagues in relation to the use of restrictive practice. We were, therefore, concerned that there was a divide in opinion between the staff working at the service, which may impact on the quality of care delivered to patients. We raised our concern to the trust.

The service completed a review of seclusion practice and found there were some gaps where medical reviews were not always completed when they should have been. The service also asked a consultant from another service to review their use of rapid tranquilisation and found that the occurrences were relatively low in comparison to other services. A review of seclusion records during the inspection showed some gaps in seclusion records and some medical seclusion reviews lacked detail.

Managers were taking action to review staffing levels, stop lone working and were completing a thorough review of service delivery at Warren Court.

Governance

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

Our findings

The service held regular quality and risk meetings where items on the agenda included service users and carers feedback, clinical effectiveness, patient safety, safeguarding, sharing good practice, quality improvement projects and quality and risk feedback were discussed.

Management of risk, issues and performance

The service had systems and processes in place to monitor risk and performance. Managers were aware of and monitored the number of incidents and safeguarding incidents that occurred at the service. Managers had recently completed a review of staffing levels at the service and had increased their staffing levels and level of support to the service due to the high level of acuity and number of incidents of assaults between patients and towards staff by patients. The service had identified one patient whose needs required a different treatment pathway. They had been actively pursuing referrals to alternative placements over a significant period of time. This is ongoing and the service commissioned an independent review to consider the most appropriate treatment and how their needs can be met.

The service had a risk register in place which they used to record, review and manage risks to the service.

Information management

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

Engagement

We saw evidence of documentation, correspondence and meeting minutes of engagement with other stakeholders, trusts and commissioners to ensure patient needs were met. We saw the service had made multiple attempts to secure transfer to more appropriate services for one patient to meet specific needs, but that these had, to date, been unsuccessful. Referrals and assessments were ongoing and followed advice provided from previous assessments.

Staff survey results from 2020 showed some areas where staff views relating to morale, feeling valued and supported were poor. For example, results showed that just 21% of staff felt that immediate managers involved them before making decisions that affected their work. 36% felt their managers valued their work, 29% of staff believed communication between senior managers and staff were effective and 29% believed that senior managers acted on staff feedback.

Following feedback from staff in relation to the high acuity levels and levels of aggression towards staff from and between patients, managers provided various interventions to support staff well being. These included increasing staffing levels at the unit, increasing team leader and senior nurses' presence, additional psychological therapy support for staff, out of hours clinical leads meeting with staff and patients, matron coffee surgeries, swarms and reflective practice sessions.

Learning, continuous improvement and innovation

Staff were developing an acceptance and commitment therapy group programme for men with a learning disability at the service. This was being evaluated but demonstrated some improvement to the patients' psychological functioning scores and some behavioural change in relation to the severity of incidents observed.

The trust had introduced Equine therapy to the service following funding from the innovation fund. This was for one year and would be evaluated.

Our findings

The trust had a reducing restrictive practice care quality improvement project and a project on improving staff moral in progress where they looked at ways to reduce the length of long term segregation for patients and increasing staff morale and job satisfaction.

Our findings

Areas for improvement

Action the trust MUST take to improve:

- The trust must ensure patients have access to regular patient forum meetings. Regulation 9 (3)(b)
- The trust must ensure that all seclusion records are completed in accordance with the Mental Health Act Code of Practice. Regulation 17 (1)(2)(c)
- The trust must ensure all specialist training delivered to staff is recorded. Regulation 17 (1)(2)(d)(i)
- The trust must ensure that duty rotas accurately record when staff are moved between houses. Regulation 17 (1)(2)(d)(ii)
- The trust must ensure staff fully complete patient observation allocation sheets. Regulation 17 (1)(2)(c)
- The trust must ensure staff receive specialist training relevant to their role. Regulation 18 (1)(2)(a)
- The trust must ensure staff receive regular staff meetings. Regulation 18 (1)(2)(a)

Action the trust Should take to improve:

- The trust should continue to review staffing levels to ensure staff are not rostered to work on their own.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one CQC inspection manager and an expert by experience. A Mental Health Act reviewer assisted in review of Mental Health Act paperwork. The inspection team was overseen by a Head of Hospital 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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing