Hertfordshire Partnership University NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWRF3	Little Plumstead Hospital	Broadland Clinic	NR13 5EW

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

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

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Are services safe?	
Are services effective?	

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

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

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

Summary of findings

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Summary of findings

Overall summary

We found the following areas of concern:

- There were three incidents of physical restraint where staff used techniques which were not taught for this environment. This could compromise both the safety of staff and patients, and was undignified for the patients involved. We identified that these three incidents were not reported to the local safeguarding team until we bought this to the trust's attention. We were not assured that the safeguarding was effective for the patients.
- Staffing levels impacted negatively upon patient care. The hospital regularly worked below the recognised optimum staffing levels. Some patients escorted leave had to be cancelled, some planned activities were cancelled, and planned visits from family on one occasion had to be postponed.
- The one seclusion room across the hospital did not meet the Mental Health Act Code of Practice. There was no effective two way communication system, the light could not be dimmed, and the temperature was cold. We were not assured that staff controlled the temperature to maintain patient comfort while in seclusion. The location of the seclusion room did not ensure that privacy and dignity of the patient was maintained at all times.
- We observed that there were poor lines of sight across all wards. Mirrors in place did not mitigate this risk. The up to date risk assessment did not actively identify what actions the staff had to take to minimise the risk of a patient using a ligature. There was not enough staff to always ensure that communal areas had a staff presence.
- The clinic used a risk assessment tool which reflected the risks of patients. Not all incidents were transferred to the risk assessment in a timely way.
- Not all care plans were representative of the patients' current needs. Two patients who were on a medication which required close physical health monitoring due to potential serious side effects, did not have a care plan in place to reflect this.
- Staff were not receiving regular clinical or management supervision in line with the trusts policy.
- Some areas of mandatory training fell below 75%.
- We observed some building works being undertaken at the time of inspection. We saw that patients who had unescorted leave could have accessed an area which contained numerous tools and building equipment.

However:

- The clinic rooms were fully equipped, with accessible resuscitation equipment and emergency medications which were checked regularly by staff.
- The wards were clean, had adequate furnishings and were well maintained.
- There was adequate medical cover throughout the 24 hour period.
- Staff undertook a comprehensive assessment of all new patients upon admission.
- The use of rapid tranquillisation was kept to a minimum, and was always clinically indicated.
- There was good medications management across the clinic, with good pharmacy support.
- There was good access to physical healthcare for the patients who required this.
- Staff had received annual appraisals.
- Staff had a good working knowledge of the Mental Health Act and the Mental Capacity Act.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We found the following areas of concern:

- On three occasions, staff had used restraint techniques which were not taught. This posed a risk of physical injury to both the patient and staff.
- Staff did not always report all safeguarding matters to the local safeguarding team in a timely manner.
- The wards had poor lines of sight with several identified blind spots. Mirrors were in place but did not mitigate the risks fully. Ligature risk assessments had been completed, but did not inform staff how to manage and minimise these risks in detail. We found that the area as you entered the hospital just past reception did not have a ligature risk assessment, as it was thought of as a non patient area. However, we saw patients being escorted through this area when entering and leaving the hospital. We also identified numerous potential ligature risks.
- The hospital frequently had below the optimum staffing levels on duty. This impacted negatively upon patient care.
- The one seclusion room across the hospital did not meet the requirements in the Mental Health Act Code of Practice. In addition to this, patients had been secluded in the de-escalation room and in bedrooms on 12 occasions since January 2017, when the seclusion room was in use. These were not fit for purpose due to the poor lines of sight and the patient being able to get hold of objects which could be used to harm themselves or others.
- Not all staff were up to date with elements of their mandatory training.

We also found the following areas of good practice:

- The hospital had fully equipped clinic rooms with accessible resuscitation equipment which was checked regularly by staff.
- All wards were clean, had adequate furnishings and were well maintained.
- Staff undertook a thorough nursing and medical assessment of patients upon admission to the hospital.
- All staff were aware of what incidents needed to be reported and were confident in doing this via the internal reporting process.

Are services effective?

We found the following areas of concern:

Summary of findings

- Risk assessments were not always updated in a timely fashion when there was a new risk identified, or following incidents.
- Care plans did not always reflect the current needs of the patients. Particularly in relation to some prescribed medications.
- Staff did not have regular clinical or management supervision in line with the trust policy.
- Not all staff felt that the hospital induction was adequate in relation to the patient group.

We also found the following areas of good practice:

- The hospital offered different psychological therapies as recommended by the National Institute of Health and Care Excellence.
- Staff received some specialised training in order to assist them fulfil their roles.
- Mental Health Act documentation was examined by a competent staff member upon admissions.
- Staff had a broad understanding of the Mental Capacity Act and the guiding principles.

Summary of findings

Information about the service

The Broadlands Clinic is part of the trust's forensic / secure services providing assessment, treatment and rehabilitation for patients with serious, complex and enduring mental health disorders.

The Broadland Clinic is a 25 bedded, medium secure male unit based at Little Plumstead Hospital in Norwich. The clinic is divided into four wards. Hathor is the admission, assessment and treatment ward with eight beds. Olive is the continuing complex needs ward with five beds. Vega is the rehabilitation and treatment ward with six beds. Mayflower is a pre-discharge ward with six beds. Patients across the hospital have different diagnosis to include a mild, borderline learning disability, mental health problems or personality disorder. At the time of inspection there were 18 patients.

The Care Quality Commission last inspected the Broadlands Clinic as part of a comprehensive inspection between 27 April and 01 May 2015. Following that inspection we rated the service as good overall. We rated; safe as requires improvement, effective as good, caring as good, responsive as good and well led as good.

At the inspection in 2015, we found that the unit was in breach of Regulation 18 HSCA (RA) Regulations 2014: Staffing during the last inspection. We required the trust to review the effectiveness of their staff recruitment and retention policy and procedures at Broadland Clinic to ensure adequate staffing. The trust were told that there should be sufficient numbers of suitably qualified, competent,skilled and experienced persons deployed in order to meet the requirements.

Our inspection team

The team comprised of one inspection manager and three inspectors.

Team Leader: Tracy Newton, Inspection Manager mental health hospitals.

The team would like to thank all those who met and spoke to inspectors during the inspection.

Why we carried out this inspection

We carried out this inspection following concerns raised by a member of the public, and following a review of information received from the trust about the service.

How we carried out this inspection

This was an unannounced, focused inspection. The team looked at two key questions in response to concerns raised:

- Is it safe?
- Is it effective?

During the inspection visit, the inspection team:

- visited all four of the wards, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with the team leaders of the wards
- spoke with 15 other staff members; including the modern matron, the service lead, doctors, nurses, mental health practitionors, occupational therapists and health care assistants
- attended and observed one hand-over meeting
- examined 11 care records of patients
- carried out a specific check of medication management on all wards
- visited the activity day centre on site

Summary of findings

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 10 patients who were using the service.

- Nine of the ten patients made some reference to staff shortages. Two patients said that they were aware that on one occasion, staff had pulled their alarms for assistance and had not had staff respond. One patient said that they tried to break up a fight to help the staff, although staff told them they should not have intervened. One patient told us that staff had used inappropriate techniques during restraints, including on one occasion bending their wrist back which caused pain. The patient reported this to senior staff who looked into this. An investigation was undertaken at the time of the complaint, and staff reported this to the local safeguarding team. Feedback given to the patient was that the staff used a proportionate response to the situation at the time.
- One patient said that they had waited for a cup of tea for over 30 minutes. Another patient spoke about having to wait for medications, as there was often only one nurse working across two wards, and on occasions all four wards.
- Six of the ten patients spoke about escorted leave having been cancelled due to staffing problems. One patient said he felt degraded as staff wore their uniform when escorting patients on leave.
- Three out of the ten patients said that activities had been cancelled due to staffing difficulties.
- One patient said that they had heard staff discussing other patients in communal areas which were not private.
- Four of the ten patients interviewed told us that they did not always feel safe on the wards. One patient spoke highly of the staff who helped keep him calm when there was incidents on the ward.
- Three patients expressed that they wanted keys to their bedrooms, but were not allowed. Staff did issue keys to some patients, based on the patients risk assessment.
- Most patients knew what section of the Mental Health Act they were detained under, and said that staff explained and discussed their rights under the Act with them regularly.
- Two patients felt happy with their care and felt their physical health care needs were being met.
- One patient spoke at length about the activities they participated in and was really pleased they had the opportunity to do this.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure the seclusion room meets the Mental Health Act code of practice.
- The trust must ensure environmental risk assessments are completed for all patient areas.
- The trust must ensure lines of sight are risk assessed within ward environments.
- The trust must ensure restraint practice adheres to trust policy.
- The trust must ensure a review of staffing levels to ensure safety of patients..
- The trust must ensure staff receive and document superivison.
- The trust must ensure clinical risk assessments are robust, up to date and reflect changes in patient status after incidents.
- The trust must ensure that care plans are representative of patients' current needs.
- The trust must ensure that staff receive mandatory training in line with trust targets.

Action the provider SHOULD take to improve

- The trust should ensure that environmental risks are considered when building works are scheduled.
- The trust should consider the dignity of patients when staff are escorting them on leave.

Summary of findings

- The trust should ensure that Section 17 leave is not cancelled for non clinical reasons.

Hertfordshire Partnership University NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Broadland Clinic	Little Plumstead Hospital

Mental Health Act responsibilities

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

- All patients across the clinic were detained under the Mental Health Act.
- Mental Health Act training was mandatory for staff, 72% had completed this. Staff interviewed had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Staff had completed Mental Health Act paperwork correctly and detention paperwork was up to date.
- Medical staff completed consent to treatment and capacity assessments. Staff attached copies to medication charts to ensure they administered medication in accordance with the Act.
- Staff regularly explained to patients what their rights were under the Act.
- Patients had access to advocacy services through a referral system, which staff assisted them with.
- Patients had access to section 17 leave, which was granted by the consultant on either an escorted or an unescorted basis. Documentation was clear in respect of the frequency and length of leave granted. If patients were detained under part 3 of the Mental Health Act for having committed a criminal offence, the consultant liaised with the Ministry of Justice.
- Senior staff completed a review of leave and reduced it in line with similar services. As a result, on Hathor and Olive wards, patients would be given up to two hours leave per week, and some additional leave over the weekend every few weeks. On Vega and Mayflower wards, patients would be given up to four hours leave per week, and some weekend leave every few weeks.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed Mental Capacity Act and Deprivation of Liberty and safeguards training which was mandatory. A total of 79% of staff had completed training in the Mental Capacity Act; 69% had completed Deprivation of Liberty and Safeguards training. Staff interviewed had a broad understanding of the Mental Capacity Act. Staff were able to explain the main principles of the Act, and talk about how this may be applied in practice.
- Staff knew how to access the trusts' Mental Capacity Act policy and additional information about the Act through the staff intranet system.
- Patients' mental capacity was discussed in clinical reviews and recorded in care and treatment records. One example we saw of this was a capacity assessment around the ability to plan and manage finances. The assessment was re-visited and reviewed as expected.

Are services safe?

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

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

Our findings

Safe and clean environment

- The layouts of the wards did not enable staff to observe all parts of the ward. There were blind spots. Mirrors had been used to maximise visibility. However, even with the mirrors there was some difficulty with observing patients in some areas. Staff told us they managed this risk by having staff designated to areas of the wards highlighted as having poor lines of sight. However, we saw areas of the wards without these designated staff, leaving patients unsupervised.
- The wards had ligature risk assessments which had been updated in June 2017. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The risk assessments highlighted areas of risk. However, how staff minimised risks was not clear. Actions needed to be taken by staff to reduce risks was recorded as "manage". This did not provide staff with what specific actions they needed to take in order to manage and minimise the risks on the wards. The risk assessment did not cover an area the hospital considered to be a non patient area, as you entered the hospital, just beyond the air lock. This area consisted of numerous rooms including two meeting rooms, several staff offices and a toilet. We observed several ligature risks in this area, and observed patients being walked through this area to exit and enter the hospital. This was bought to the attention of senior staff upon inspection, who immediately started to undertake an assessment of this area.
- The wards admitted men only and therefore complied with Department of Health guidance on eliminating mixed sex accommodation.
- There were two clinic rooms across the four wards. Both were fully equipped and contained accessible resuscitation equipment and emergency medications. These were checked regularly by staff.
- There was one designated seclusion room across all four wards, located on Hathor ward. At the time of our visit this was being redecorated. It had an observation area where staff could see a patient while in seclusion. We noted that the observation was slightly obstructed in the toilet area, as there was some privacy screening on the observation window. However, there was a mirror placed in this area to maximise patient observation. There was no two way communication system in place. This had been damaged by a patient. Staff had been communicating with patients in this area by raising their voices to enable them to hear. It was unclear how long the room had been without a two way communication system. The seclusion room was opposite a de-escalation room, and in close proximity to a laundry room. Therefore the privacy and dignity of a patient in seclusion could be compromised. There was no shower facility, although there was a sink, enabling a patient to attend to personal care. There was a clock which would be visible to the patient. Upon inspection we observed that the seclusion room and the de-escalation room appeared very cold. Staff told us that the last patient being nursed in seclusion did complain about this. Staff explained that temperature controls for these areas were located in the nursing office. The seclusion room did not meet the Mental Health Act Code of Practice requirements. Yet staff confirmed that it would be used if required.
- There had been occasions whereby patients had been secluded in the de-escalation room, or in their bedrooms, when the seclusion room was in use. These areas did not allow clear observation, and bedrooms would contain items that could potentially cause harm. We found that one patient who had been secluded in the de-escalation room had caused significant damage and an electrician had to be called in to repair it. On another occasion when a patient was secluded in their bedroom, they produced a weapon. The police had to be called in to assist with transferring this patient to the seclusion room.
- All four wards were clean, had adequate furnishings and were well maintained. The environment was regularly cleaned by housekeeping staff, who worked over the seven days throughout the hospital. The patient led assessment of the care environment (PLACE) scored 100% for cleanliness in 2016. PLACE assessments are self assessments undertaken by at least 50% of members of the public.

Are services safe?

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

- Staff adhered to infection control principles. We saw that protective aprons and gloves were available. There was adequate hand washing facilities and hand gel available to staff.
- Equipment across the wards were well maintained, clean and had undergone appropriate testing to ensure they were safe to use.
- Appropriate environmental risk assessments were undertaken regularly. This included outside areas and examination of the perimeter fence. During inspection we observed some building works taking place just off of the reception area. An adjoining door off of reception had been removed. We saw workmen with numerous tools in this area. Later in the day we observed that a door had been fitted. However, this was unlocked and the area through the door was unsupervised. We saw that there were further building equipment outside within a small fenced area. There was a gap in this fencing and so potentially a patient who had unescorted leave could have accessed this. We raised this during inspection and senior staff assured us that any patient who had any leave would have been risk assessed by the nurses prior to leaving the building. It is acknowledged that the works were being undertaken outside of the secure perimeter. However, the risk remained.
- All staff were issued with personal alarms which were tested routinely. We saw staff respond quickly during the inspection when the alarm for assistance was raised.

Safe staffing

- At the time of inspection the hospital had five registered nurse vacancies and nine unregistered vacancies. Active recruitment was ongoing.
- The provider had estimated the number and grade of nurses required each shift. At the time of inspection the clinic viewed that a total of 13 staff across the hospital (covering all four wards) during the day was the optimum level. This number reduced to nine throughout the night. The trust had employed mental health practitioners to support registered nurses. These staff members were registered professionals, such as occupational therapists. On the staff rota, we observed that these were counted as registered nurses. Mental health practitioners could not undertake all duties a registered nurse could; for example, administering medications and undertaking a patient risk assessment prior to authorised leave being taken. Examination of the staff rotas between 02 July and 09 September 2017 showed that only 21% of shifts had met these optimum staffing levels. The rotas did not reflect activity on the wards, for example when patients were on enhanced observations; in seclusion or in long term segregation. Senior staff informed us that staff were encouraged to complete incident forms around staffing levels. If the staffing numbers fell below nine staff during the day, and below seven thoughout the night, staff completed an incident form as these numbers were thought to be unsafe. We found that the impact on staff shortages had a negative impact upon patient care. On one occasion staff had telephoned families to cancel planned visits due to lack of staff. On another occasion, a patient being nursed in long term segregation was denied access to fresh air as there was not enough staff to facilitate this. Staff had also recorded that on one occasion they suspected a patient had been smoking in his bedroom. However a room search had not been conducted until the following morning due to staffing. We observed that staff did not always have breaks. Staff confirmed this when interviewed.
- The clinic utilised bank and agency staff regularly. Shifts were offered to substantive staff initially, and then offered to bank and then agency if shifts could not be covered. The clinic was block booking some regular nurses through the agency to help achieve consistent care.
- The team leaders were able to adjust staffing levels to ensure that the patients needs were met. The team leaders told us that on occasions they would undertake clinical shifts on the wards if required.
- We saw that there was not always a staff member present in communal areas on the wards throughout the inspection.
- Staff reported that they had adequate time to spend one to one time with allocated patients. We saw some evidence of this being recorded in the patient's daily notes.
- Three patients we spoke with told us that planned activities had been cancelled due to staffing difficulties. On the second day of inspection, we observed that the activity centre (The Wherries) was closed as they did not have the staff to safely facilitate planned sessions. However, staff informed us that this was a rare occurance.

Are services safe?

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

- Of the 17 staff interviewed, 15 talked about not having enough staff to facilitate patients escorted leave. Six of the 10 patients we spoke with said that they had experienced cancelled leave due to staff shortages. Senior staff completed a review of leave and reduced it in line with similar services. On Hathor and Olive wards, patients would be given up to two hours leave per week, and some additional leave over the weekend every few weeks. On Vega and Mayflower wards, patients would be given up to four hours leave per week, and some weekend leave every few weeks. We looked at section17 leave forms which confirmed the above. This would not include medical appointments, for which separate leave would be authorised.
- There was adequate staffing across the clinic to enable a response if physical assistance was required. However, if there was more than one incident occurring at any one time, this could prove difficult with safe management due to overall staffing levels.
- The clinic had adequate medical cover throughout the 24 hour period. Doctors were able to attend the wards quickly in the case of an emergency.
- The trust provided us with an overall rate for compliance with mandatory training which was 78%. We observed some rates were below 75% in the following areas: Deprivation of Liberty and Safeguards (69%); Infection control (67%); MHA (72%); moving and handling – level 1 (40%), level 2 (67%); and the safeguarding of vulnerable adults (61%).

Assessing and managing risk to patients and staff

- The clinic reported that there had been 22 incidents of seclusion between 02 July and 09 September 2017. These involved four different patients.
- The clinic reported one patient who had been nursed between seclusion and long-term segregation within the same time period.
- There had been 35 reported incidents of physical restraint between June and August 2017. These restraints involved three different patients on Hathor ward. Of these three resulted in a patient being restrained in the prone position (chest down). The hospital undertook an investigation when a patient had been restrained in the prone position and discussed findings during monthly meetings around risk.
- Staff told us restraint was used as a last resort, with emphasis on de-escalation as a first approach where possible. The trust reported that 100% of staff had been trained in the four day course around restraint, and a further 78% of staff had received an additional days training, which related more to the use of restraint and seclusion for patients in high risk areas. The trust did not confirm what training in restraint agency staff received. Therefore we could not be assured that all restraints were being undertaken safely. We found three incidents whereby patients had been restrained and relocated to the seclusion area by staff, using techniques not taught. On one occasion, a duvet was placed under a patient to enable staff to transfer to the seclusion room. On another occasion, staff had turned a patient into the prone position and physically lifted to the seclusion area. A third incident highlighted that staff "dragged" a patient on their clothes to the seclusion area. This compromised the safety of both staff and patients, and was undignified for the patients involved.
- We examined 11 patient records. Staff aimed to undertake the commencement of a comprehensive risk assessment prior to a planned admission. The multidisciplinary team then completed this in full following admission. We found that staff had not reviewed six of the 11 risk assessments at six monthly intervals. Staff did not update these following incidents, and so current or increased risks were not always captured in a timely way. Staff told us that risks and incidents would be discussed at the regular multi-disciplinary meetings. However, we saw minimal discussion in the patients' notes of this occurring. Staff told us that they used to use a separate risk assessment tool – short term assessment of risk and treatability (START) as a live risk assessment. However, staff on Hathor and Olive wards were no longer using these. We saw three START assessments which had been completed on Vega and Mayflower wards.
- Restrictions upon patients were risk assessed. For example, patients had access to mobile telephones on leave. Patients were able to utilise a computer and had access to the internet. We found that there was a blanket restriction on dressing gown cords. This was introduced across the entire trust following a significant incident. The clinic did provide dressing gowns to patients upon request, which had buttons instead of a cord.
- The clinic had a policy and procedure around the use of enhanced observations. Patients were searched following any periods of leave, and random room searches were carried out in line with their policies.

Are services safe?

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

- Staff avoided the use of rapid tranquillisation. No patient had recieved this recently at the time of inspection. Patients would not be prescribed this unless clinically indicated.
- We examined a sample of 17 seclusion records. Staff followed best practice when monitoring the patient regularly and recording this. We found that 13 out of the 17 patients had a specific care plan around being nursed in seclusion. Documentation was not explicit in terms of where the patient was secluded.
- Not all staff were trained in the safeguarding of adults and children. The trust reported that 61% of staff had received training in the safeguarding of adults, and 75% had undertaken training in the safeguarding of children. Staff knew how to make a safeguarding alert and could give examples of when they had done this. However, we identified that three incidents of restraint using untaught techniques were not reported to the local safeguarding team until we brought this to the trust's attention. They were reported retrospectively on the 13 October 2017. These incidents occurred in July and August 2017. We were not assured that appropriate safeguarding of the patients was effective, or that patients were always protected from abuse and improper treatment.
- The wards had weekly support from a pharmacist who checked stock levels; disposed of controlled medications and provided advice as and when necessary. We saw appropriate medications management.
- There were safe procedures for children visiting. This was discussed during the multi-disciplinary reviews. The social worker would ensure that all necessary risk assessmsents and communications with external agencies (where appropriate) had taken place. There was an allocated room within the building, external to the wards.

Track record on safety

- Over the last six months, the hospital reported two serious incidents. One was in relation to medication. The second was in relation to a serious assault on a staff member.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents needed to be reported and knew how to report using the internal reporting system. We saw incidents that should be reported had been reported.
- Staff said that they were candid with patients and were honest if things went wrong.
- Senior staff confirmed that they received feedback from investigations of incidents, both internal and external to the hospital. The hospital held regular meetings whereby incidents were discussed, and identified learning was shared. Information was then cascaded to the staff teams on the wards through team meetings, and also through emails staff received.
- One example of change following a serious incident, was dressing gown cords being prohibited across the trust.
- Five of the staff interviewed confirmed that they received de-briefs and support following a serious incident. Incidents would be discussed towards the end of their shifts, or during a hand-over. Senior staff felt that as a service they were improving upon this.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- We examined 11 care records. We found that a comprehensive and timely assessment was completed upon or shortly following admission.
- The doctors completed a physical health examination upon admission where possible. Routine annual health checks of patients were in place.
- We found that the majority of patients with ongoing physical health problems had appropriate care plans in place. Referrals to appropriate health care professionals had been made.
- Care plans were in place but they were not always comprehensive and did not always reflect the needs of the patients. For example, one patient who attended college did not have a care plan in place to reflect this, and no plans around future discharge. Another patient was prescribed a medication for high cholesterol, but there was not a care plan in place around the management and monitoring of this. Two patients were prescribed a particular medication which could have serious side effects and therefore required regular monitoring. Neither patient had a care plan in place around this.
- Most care plans were personalised, holistic and recovery orientated.
- Patient information was stored securely electronically. Some documentation was initially completed on paper and later scanned onto the system. This made care notes accessible to health care professionals across the service.

Best practice in treatment and care

- Staff followed the National Institute of Health and Care Excellence guidance when prescribing medications. Antipsychotic medication was prescribed within recommended limits and routine monitoring of patients was in place.
- The clinic had two psychologists in post who offered psychological therapies to patients. The clinic offered group work as well as individual therapy. Examples of which included schema therapy; cognitive behavioural therapy; offence related work and moral reasoning.
- The clinic had good access to physical healthcare. A nurse attended the clinic weekly, and a GP monthly. We saw that patients had been referred to other specialists where necessary, such as a podiatrist and a diabetic nurse specialist.
- Staff used recognised rating scales to assess and record care outcomes. An example of this was the health of the nation outcome scales.
- Staff told us that the matron undertook clinical audits regularly. Examples of these included infection control, medication audits, equipment audits and care plan audits.

Skilled staff to deliver care

- The clinic had a full range of mental health disciplines and workers who provided input into patient care. These included psychiatrists, doctors, psychologist, occupational therapists, registered nurses in mental health; learning disabilities and general nursing, mental healthcare practitioners (registered professionals), health care assistants and a social worker. There was a range of experience within the team.
- At the time of inspection, all staff completed a trust and local induction. The local induction consisted of one week on the wards, and then staff worked as 'additional staff' until they had completed their restraint training. Staff gave mixed reviews about their experience of the induction to the clinic. For example, one nurse reported a very good induction, and had the opportunity to work alongside another nurse for two weeks before taking charge of the shift. A support worker told us that their induction period was not satisfactory in terms of the time given to get to know the patient group. However, senior staff told us that the service had recently developed a one month induction for all staff.
- Staff teams had regular meetings which were minuted. As of 19 September the trust reported that the appraisal rate was 85%. We looked at a sample of staff appraisals and found that 10 out of 15 staff had received an appraisal. Staff reported that supervision was planned, and was a mix of clinical supervision and management supervision. However, planned sessions were frequently postponed due to how busy the wards were. As of 19 September 2017 the trust reported that the supervision rates across the clinic was only 56%. We looked at a sample of 30 staff supervision records. We found supervision rates documented was just 13%. This was

calculated by assuming that the staff member should have received supervision as a minimum every 8 weeks. This was the maximum interval staff should go without having supervision, as stipulated in trust policy.
- Staff received specialist training for their roles. Examples of this included positive behavioural support plan training; autism awareness; personality disorder training and risk training.
- Team leaders and the modern matron had the authority to address poor staff performance, and could receive support in doing this.

Multi-disciplinary and inter-agency team work

- Each ward held regular multi-disciplinary meetings which were documented. Different members of the team attended. On one occasion, we saw that a nurse from the ward could not attend due to staffing difficulties.
- Hand-overs took place at the commencement of each shift. At the time of inspection, staff worked a mixture of long days and half days. Therefore there were three hand-over periods each day. The morning hand-over was 30 minutes, other handovers were one hour. Staff felt this was adequate to pass over information between shifts. We observed one handover meeting which we found was comprehensive.
- Staff contacted other healthcare professionals, such as care co-ordinators regularly to update on progress and invite to professional meetings.
- The clinic reported good working relationships with teams outside of the organisation, such as the local safeguarding team.

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

- Mental health papers were examined by the Mental Health Act administrators upon admission to ensure they were correct.
- Staff knew who their Mental Health Act administrators were and knew how to contact for advice as and when required. The administrators ensured that the Mental Health Act was followed in relation to renewals of detention; consent to treatment and appeals against detention. Administrative support and legal advice on implementation of the Mental Health Act and its code of Practice was available to ward teams.
- The wards kept clear records of leave granted to patients. These included number and gender of escorts; any restrictions; the date and duration of leave, and the parameters of leave.
- At the time of inspection the trust reported that 72% of staff had received training in the Mental Health Act, which was mandatory. Staff interviewed had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Consent to treatment and capacity requirements were adhered to. Copies of consent to treatment forms were with the patients medication charts.
- Staff explained and discussed rights under the Mental Health Act with patients upon admission to hospital and routinely thereafter.
- Detention paperwork was filled in correctly, up to date and stored appropriately.
- Patients had access to advocacy services through a referral system. Staff supported patients with this if needed.

Good practice in applying the Mental Capacity Act

- Training in the Mental Capacity Act was mandatory. The trust reported that 79% of staff had received this.
- There had been no Deprivation of Liberty applications made over the last six months.
- Staff interviewed had a broad understanding of the Mental Capacity Act. Staff were able to explain the main principles of the Act, and talked about how this may be applied in practice.
- The trust had a policy around the Mental Capacity Act and Deprivation of Liberty and Safeguards which staff could refer too. Staff knew that this was located on the intranet.
- Staff assumed patients had the capacity to make decisions for themselves, and encouraged this. If staff felt that a patient lacked capacity around a particular issue, a capacity assessment would be completed by the most relevant team members and recorded. One example we saw of this was a capacity assessment around a patients ability to plan and manage finances. Patients were supported to make decisions where appropriate. Any decisions made around care and treatment on behalf of someone who lacked capacity was completed in their best interests, in line with the Mental Capacity Act.
- Staff knew they could approach the Mental Health Act administrators for advice around the MCA.

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 18 HSCA (RA) Regulations 2014 Staffing • The trust did not ensure that all staff received mandatory training. This was a breach of Regulation 18.

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 • The trust did not ensure that care plans were fully reflective of patients needs. This was a breach of Regulation 9.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care **During our inspection, we found failings with:** 1. Seclusion environments 2. Restraint practice 3. Risk assessments and clinical records 4. Ligature point management and environmental risks pertaining to lines of sight 5. Staffing levels 6. Supervision of staff **The provider is required to make the significant improvements identified above regarding the quality of healthcare by 31 January 2018.**