St Andrew's Healthcare - Womens Service

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services well-led?	

Overall summary

We did not rate this service.

We carried out this inspection in response to concerning information received through our monitoring processes.

We found the following areas the provider needs to improve:

- Managers did not ensure established staffing levels on all shifts. The provider reported that 1,698 shifts out of 15,788 were unfilled for the period 1 February 2018 to 30 June 2018. This equated to a fill rate of 89% against the provider target of 90%. There were not always enough staff to safely carry out physical interventions and provide the required level of patient observations on Sunley ward. We reviewed seven incident reports. Staffing levels at the time of the incidents were recorded in each report. Staffing was below the establishment number for five incidents reviewed.
- The provider was not compliant with the Mental Health Act Code of Practice. We reviewed 22 out of 115 seclusion records from 1 April 2018 to 30 June 2018. Doctors and nurses did not complete records for all of the reviews as required by the Mental Health Act code of practice. Staff had not completed seclusion and long-term segregation care plans for all patients. The multi-disciplinary team had not conducted reviews as required. Sunley and Bayley ward seclusion rooms had

Summary of findings

blind spots in the ensuite areas, although the provider reported these immediately. Staff did not always provide patients with information about their rights under the Mental Health Act.

- Managers had not ensured a safe environment at the learning disabilities service. Whilst managers and the health and safety lead had completed ligature audits for Spencer North and Sitwell wards within the last six months prior to inspection, there was no hard copy of the ligature audit and assessment available. Staff on Spencer North did not know where to find the ligature audit. Staff had not received the necessary specialist training for their roles on Sunley ward. There had been an incident one weekend where there were no nasogastric trained staff available to administer the nasogastric feeds to a patient requiring this intervention.
- Staff had not followed the dysphagia care plan for one patient on Sitwell ward, which had resulted in a choking incident. Staff administered backslaps and dislodged the food.
- Managers did not share learning from incidents with their teams in the forensic and learning disabilities services. We reviewed ten team meeting minutes from January 2018 and weekly memos from 1 June 2018 sent by managers to staff and there was evidence of one incident being discussed in one meeting. The provider told us they shared learning from incidents via alerts sent by email. However, staff told us that they would hear of incidents on other wards by word of mouth rather than through any formal means.
- Staff did not always follow National Institute for Health and Care Excellence guidance for the use of rapid tranquillisation on Sunley ward. Staff told us that rapid tranquillisation medication was administered most days. We reviewed one patient's records who had been administered rapid tranquillisation medication twice in one day. Staff had not completed the required physical health checks following both administrations.
- There were blanket restrictions on Sunley ward. Staff told us patients' snack times on the ward were 11am and 4pm. Staff did not allow patients to have snacks outside these times.

However, we found the following areas of good practice:

- Staff told us that they received de briefs and support after serious incidents. This included visits from senior managers, support from the provider's trauma manager and free access to a confidential helpline. We reviewed minutes from a de brief session, which confirmed this.
- Managers had implemented additional safety measures following serious incidents, these included updating the ligature audit and assessment following a ligature incident, ensuring staff with specific training were available to provide specialist support to patients and a review of patients' access to contraband items.
- Staff ensured most patient's needs were assessed and met within care plans. We reviewed 21 care and treatment records for patients. Staff had completed person centred and holistic care plans for 20 patients reviewed. Staff had completed physical health assessments for patients on admission accessed specialist healthcare providers when needed.
- Patients had good access to physical healthcare when needed. A physical healthcare team, based on site, were available during the week to offer support with patients' physical healthcare needs. Staff could access emergency physical health care from the provider's emergency response teams and the local general hospital to cover out of hours emergencies.

Summary of findings

Contents

Women's services St. Andrews

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards; Wards for people with learning disabilities or autism;

Summary of this inspection

Background to St Andrew's Healthcare - Womens Service

St Andrew's Healthcare Northampton has been registered with the CQC since 11 April 2011. The services have a registered manager and a controlled drugs accountable officer.

Northampton is a large site consisting of more than ten buildings, over 50 wards and has 659 beds. There are four locations registered at Northampton; adolescent services, men's services, women's services and acquired brain injury (neuropsychiatry) services.

St Andrew's Healthcare also has services in Nottinghamshire, Birmingham and Essex.

The four locations at St Andrew's Healthcare, Northampton have been inspected 23 times since April 2011. The last inspection was of the men's service in March 2018.

Patients receiving care and treatment at St Andrew's Healthcare follow care pathways. These are women's mental health, men's mental health, autistic spectrum disorder, adolescents, neuropsychiatry and learning disabilities pathways.

We inspected women's services to follow up on concerning information received through our monitoring processes.

The following services were visited on this inspection:

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

• Bayley ward is a psychiatric intensive care unit with 10 beds.

All patients receiving treatment in this service are detained under the Mental Health Act (1983).

Forensic inpatient/secure wards:

We inspected the following wards in women's services:

• Seacole ward is a medium secure ward with 15 beds.

• Sunley ward is a medium secure ward with 14 beds.

All patients receiving treatment in this service are detained under the Mental Health Act (1983).

Wards for people with learning disabilities or autism:

We inspected:

• Sitwell ward, a 14 bed medium secure service for women with learning disabilities and /or autistic spectrum conditions.

• Spencer North ward, a 15 bed low secure service for women with learning disabilities and/or autistic spectrum conditions.

All patients receiving treatment in this service are detained under the Mental Health Act (1983).

The learning disabilities (LD) pathway provides care and treatment for adults with mild to moderate learning disabilities and other neuro-developmental disorders who have offended or display behaviour which challenges. People in the autism services have co-existing conditions such as mental and physical illness or additional developmental disorders such as personality disorder which put themselves or others at risk.

Our inspection team

Team leader: Helen Kirton

The team that inspected the services comprised two CQC inspectors, one CQC Mental Health Act reviewer and one CQC assistant inspector.

The team would like to thank all those who met and spoke with them during the inspection and who shared their experiences and perceptions of the quality of care and treatment at the provider.

Summary of this inspection

Why we carried out this inspection

We undertook this inspection to follow up on concerning information received through our monitoring of St Andrew's Healthcare women's services.

When we last inspected this location in May 2017, the overall rating for this service was good. We rated the safe key question as requires improvement for forensic and learning disabilities services.

We rated the other key questions as good for forensic and learning disability services, apart from the caring and responsive key questions for forensic wards, which were not inspected at this inspection.

The acute and psychiatric intensive care unit was not inspected as it had not opened at the last inspection.

Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified and requirement notices issued for this service. These related to: -

Regulation 17 – good governance;

- Policies for seclusion, long term segregation and enhanced support were confusing and the long-term segregation policy did not meet the Code of Practice in respect of review requirements. We found that staff were confused about what constituted seclusion and long-term segregation. Many staff described patients as being in 'extra care' when in fact they were either secluded or in long term segregation.

Regulation 18 – staffing;

- Staffing levels did not meet the required establishment level. There was no manager in place for Sitwell ward. The staffing establishment numbers were being met on some wards at the beginning of a shift but when there was a need for increased staffing because of observations or staff need to help on other wards staffing levels were reduced because extra staff were not always found.

We found that the provider had not fully addressed these issues. We have identified the issues which remain later in this report.

How we carried out this inspection

We have reported in three of the five key questions; safe, effective and well led. As this was a focused inspection, we looked at specific key lines of enquiry in line with concerning information received. Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with eight patients who were using the service;
- interviewed the ward managers for two of the wards;
- spoke with 13 other staff members; including nurses, healthcare assistants, assistant psychologists and domestic staff;
- looked at 21 care and treatment records of patients;
- looked at 22 seclusion records and 34 Mental Health Act records;
- reviewed 14 incident records;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with eight patients during our visit.

- Three patients told us that there were not enough staff. One patient said they only get to leave the ward at weekends and would like to get out every day.

Summary of this inspection

- Four patients raised concerns about staff being attacked by other patients. Three patients told us they had been attacked by other patients and they did not feel safe.
- Two patients told us that the food was not very nice.
- One patient told us that their care and treatment was disgusting and another patient was not happy that they could not go out for a cigarette.

However;

- Patients told us that most staff were nice and another patient told us that they were attending a course to get a qualification and were hoping to work at the provider's light industry workshop.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Managers did not ensure established staffing levels on all shifts. The provider reported that 1,698 shifts out of 15,788 were unfilled for the period 2 February 2018 to 30 June 2018. This equated to a fill rate of 89%, against the provider's target of 90%. There were not always enough staff to safely carry out physical interventions and provide the required level of patient observations on Sunley ward. We reviewed incident reports which confirmed this. The provider reported 28 staff injuries on Sunley ward from 1 January 2018 to 30 June 2018. Of these, 12 were sustained during episodes of restraint.
- The provider was not compliant with the Mental Health Act Code of Practice. We reviewed 22 out of 115 seclusion records from 1 April 2018 to 30 June 2018. Doctors and nurses were not always completing reviews as required by the Mental Health Act Code of Practice. In 18% of records a medical review had not taken place within the first hour of seclusion and in 62% of cases doctors had not completed four hourly medical reviews. In 31% of cases nurses had not completed two hourly reviews. Staff had not completed seclusion and long-term segregation care plans in 32% of records. The multi-disciplinary team had not conducted reviews as required in 67% of records and external reviews by an independent hospital had not happened. Staff had not clearly recorded whether some patients were in seclusion or long-term segregation. Sunley and Bayley ward seclusion rooms had blind spots in the ensuite areas. Staff did not always provide patients with information about their rights under the Mental Health Act.
- Managers had not ensured a safe environment at the learning disabilities service. Whilst managers and the Health and Safety lead had completed ligature audits of Spencer North within the last six months, staff were not aware of where to find the audit.
- Managers did not share learning from incidents with their teams in the forensic and learning disabilities services. We reviewed ten team meeting minutes from January 2018 and weekly memos from 1 June 2018 sent by managers to staff and there was evidence of one incident being discussed in one

Summary of this inspection

meeting. The provider told us they shared learning from incidents via alerts sent by email. However, staff told us that they would hear of incidents on other wards by word of mouth rather than through any formal means.

- Staff did not always follow National Institute for Health and Care Excellence guidance for the use of rapid tranquillisation on Sunley ward. Staff told us that rapid tranquillisation medication was administered most days. We reviewed one patient's records who had been administered rapid tranquillisation medication twice in one day. Staff had not completed the required physical health checks following both administrations.
- There were blanket restrictions on Sunley ward. Staff told us patients' snack times on the ward were 11am and 4pm. Staff did not allow patients to have snacks outside these times.

However, we found the following areas of good practice:

- Staff told us they received de briefs and support after serious incidents. This included visits from senior managers, support from the provider's trauma manager and free access to a confidential helpline. We reviewed minutes from a de brief session, which confirmed this.
- Managers had implemented additional safety measures following serious incidents, these included updating the ligature audit and assessment following a ligature incident, ensuring staff with specific training were available to provide specialist support to patients and a review of patients' access to contraband items.
- The provider reported that 96% of staff had completed Management of Actual and Potential Aggression training. Staff told us that they had completed this training.
- Managers had ensured clean and well maintained environments.

Are services effective?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Staff had not received the necessary specialist training for their roles on Sunley ward. During our visit, two patients required nasogastric feeding. The ward manager was the only staff member trained to provide this intervention. Staff told us they had booked to attend this training with an external agency but the agency cancelled this. There had been an incident one weekend where there were no nasogastric trained staff available to administer the nasogastric feeds.

Summary of this inspection

- Staff had not followed the dysphagia care plan for one patient on Sitwell ward, which had resulted in a choking incident. Staff administered backslaps and dislodged the food.
- Staff had not always provided patients with information about their legal status and rights, as required under section 132 of the Mental Health Act. We reviewed 34 records and this information had not been provided in 11 instances.

However, we found the following areas of good practice:

- Staff ensured they assessed and met most patient's needs. We reviewed 21 care and treatment records for patients. Staff had completed person centred and holistic care plans for 20 patients reviewed. Staff had completed physical health assessments for patients on admission and accessed specialist healthcare providers when needed.
- Patients had good access to physical healthcare when needed. A physical healthcare team, based on site, were available during the week to offer support with patients' physical healthcare needs. Staff could access emergency physical health care from the provider's emergency response teams and the local general hospital to cover out of hours emergencies.

Are services well-led?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Governance systems were not effective in ensuring shifts were covered by sufficient numbers of staff of the right grade and experience.
- We were not assured that the provider had effective systems to monitor the use of seclusion and long-term segregation to ensure they met the requirements of the Mental Health Act Code of Practice. Although the provider had reviewed their policy for seclusion and long-term segregation, we found that staff were not always clearly recording whether a patient was in seclusion or long-term segregation.

However, we found the following areas of good practice:

- Staff spoken with were aware of how to use the whistle-blowing process. Staff told us they felt able to raise concerns without fear of victimisation.
- Staff were open and transparent with patients and explained if something went wrong.

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

Safe	
Effective	
Well-led	

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Safe and clean environment

- The ward layout allowed staff to observe all parts of the ward.
- Managers had ensured that ligature risks were assessed and mitigated against in individual patient risk assessments. We saw that ligature risk assessments were updated regularly and staff were updated of amendments via email. The seclusion room door on Bayley ward had a metal hatch, which staff could open to pass food or medication to the patient, if it was not safe for staff to enter the room. There was an ensuite, with shower, toilet and hand basin. The CCTV was not working in the ensuite. Staff used the spyhole in the door to view the ensuite area. However, this meant staff were not able to view immediately below the ensuite door.
- Managers had ensured a clean and well maintained environment.
- Staff displayed hand wash posters and hand sanitiser was available on the wards.

Safe staffing

- Managers did not ensure established staffing levels on all shifts. For Bayley ward, the provider reported established staffing rates of ten whole time equivalent qualified staff and 28 whole time equivalent unqualified staff. Staff in post as of end of June 2018 equated to seven whole time equivalent qualified staff and 14.64 whole time equivalent unqualified staff.
- Staffing levels were above those usually planned on the day of our visit, (12 staff on duty, 11 planned). The manager advised they could request additional staffing as required. The manager told us that the established staffing levels were to increase following work completed by the provider looking at safe and optimum staffing levels.
- The provider used bureau (St Andrew's bank staff) and agency staff to fill vacant shifts. However, a number of shifts remained unfilled.
- The provider reported that 267 shifts out of 2,824 were unfilled for Bayley ward for the period 1 February 2018 to 30 June 2018. Of these, 74 out of 889 were unfilled qualified shifts and 236 out of 1,935 were unqualified. This equated to a fill rate of 92% for qualified staff and 90% for unqualified.
- The manager advised that they had four qualified and six unqualified vacant posts that they were recruiting to. The manager was using regular bank and agency staff to cover shifts.
- Staff spoken with raised concerns regarding the change to healthcare assistants delivering the food service as part of their roles. Hotel service staff previously provided this support. Staff told us that they had not had additional healthcare assistants allocated to the ward to replace the loss of the hotel service staff. We were told it can take two staff up to four hours a day to provide the food service. Staff told us that on weekends the food is not delivered to the ward and they have to leave the ward to fetch the food trolley.
- A qualified nurse was present in communal areas of both wards during our visit.
- Staff spoken with advised that leave was rarely cancelled due to staff shortages.

Assessing and managing risk to patients and staff

- Staff were assessing and managing risks to patients and staff. We reviewed five patient care and treatment records. Staff had completed risk assessments for all patients and reviewed these regularly. Staff used recognised risk assessment tools, for example, Historical, Clinical, Risk management 20 (HCR-20) and Short-Term Assessment of Risk and Treatability (START).
- The provider reported that 92% of staff had completed Management of Actual and Potential Aggression training. Staff spoken with told us that they had completed this training.
- There were no blanket restrictions on Bayley ward.

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

- The provider reported 125 restraint episodes on Bayley ward between 1 January 2018 and 30 June 2018. Of these, 18 were prone restraints and 38 resulted in the use of rapid tranquillisation medication. Prone restraint is a form of restraint where the patient is held in the chest down position.
- Staff told us that prone restraint was used to administer rapid tranquillisation medication or if the patient went down that way. Staff told us that some patients were not compliant with their medication and would require restraint to enable medication to be administered via intramuscular injection.
- Staff told us that rapid tranquillisation medication was administered daily.
- In the weeks prior to the inspection, the CQC conducted a review of seclusion practice. We reviewed four out of 29 seclusion records for Bayley ward from 1 April 2018 to 30 June 2018. Doctors had reviewed all patients within the first hour of seclusion but two patients did not have continuing four hourly medical reviews as outlined by the Mental Health Act 1983 Code of Practice. Nurses had not completed the required two hourly reviews for two patients. Initial internal multi-disciplinary reviews had taken place as required for patients who required this. However, staff had not facilitated independent multi-disciplinary reviews for two patients who required this.

Track record on safety

- Bayley had reported eight serious incidents from 1 July 2017 to 31 May 2018. The most commonly occurring incident types related to physical aggression and violence and self-harm with two each of the total.
- There had been an unexpected death on Bayley ward within the last 12 months. We reviewed the incident report and case notes for this incident. The patient had up to date and detailed risk assessments completed. The care plan had minimal information. Staff had assessed the patient as needing to be on five-minute observations. We reviewed the observation records, which confirmed this was being done. The providers serious incident investigation was ongoing.
- The manager had implemented additional safety measures following a serious incident, which included updating the ligature audit and assessment.

Reporting incidents and learning from when things go wrong

- The manager facilitated lessons learnt sessions with their team. We reviewed three lessons learnt sessions for March, May and July 2018. The manager had discussed a serious incident that had occurred at one of the providers other locations, potential ligature risks that had been identified on other wards and 'red top alerts' from other wards.
- We reviewed a further three incidents on Bayley ward. These related to two incidents of physical aggression and violence and one of self-harm. Staff had reported incidents to the local authority safeguarding team, where required.
- Staff told us that they received de briefs and support after serious incidents. This included visits from senior managers, support from the provider's trauma manager and free access to a confidential helpline. We reviewed minutes from a de brief session, which confirmed this.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- Staff ensured most patient's needs were assessed and met within care plans. We reviewed five care and treatment records for patients. Staff had completed holistic care plans for all patients reviewed. Staff had completed full physical health assessments for four patients on admission and four had evidence of ongoing physical health care in their records.

Best practice in treatment and care

- Staff told us that patients had good access to physical healthcare when needed. A physical healthcare team, based on site, were available during the week to offer support with patients' physical healthcare needs. Staff could access emergency physical health care from the provider's emergency response teams and the local general hospital.
- Staff had supported a patient with specific needs that were complex and challenging and involved working closely with other specialist healthcare providers. The team had received praise for their work with this individual and won a compassionate care award.

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

Skilled staff to deliver care

- Staff told us about specialist training they had received to support patients with specific healthcare needs.
- Staff told us that they had received dialectic behaviour support training, electro cardiogram training and blood taking training.
- Staff told us the physiotherapist supported them to look at how to care for a patient with particular needs.

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

- A competent staff member examined patients' Mental Health Act papers on admission. Staff knew who their Mental Health Act administrators were and how to access them. The Mental Health Act administrators supported staff with renewals, consent to treatment and appeals against detention.
- In most records, staff had provided patients with information about their legal status and rights, as required under section 132 of the Mental Health Act. However, staff had not provided this information to a patient who was detained under section 3 on 6 July 2018.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good governance

- Managers had not ensured that shifts were covered with a sufficient number of staff of the right grades and experience.
- We were not assured that the provider had systems to monitor the use of seclusion and long-term segregation to ensure they met the requirements of the Mental Health Act Code of Practice.
- Managers shared learning from incidents with staff. We reviewed three lessons learnt sessions for March, May and July 2018. The manager had discussed a serious incident that had occurred at one of the providers other locations, potential ligature risks that had been identified on other wards and 'red top alerts' from other wards.

Leadership, morale and staff engagement

- Staff spoken with were aware of how to use the whistle-blowing process. Staff told us they felt able to raise concerns without fear of victimisation.
- Staff were open and transparent with patients and explained if something went wrong.

Forensic inpatient/secure wards

Safe	
Effective	
Well-led	

Are forensic inpatient/secure wards safe?

Safe and clean environment

- The ward layout allowed staff to observe all parts of Sunley and Seacole wards.
- Managers and the health and safety lead had completed a ligature audit for Sunley ward within the last six months prior to inspection. Managers had identified ligature points and mitigated against these through individual patient risk assessments and increased observations. We did not review the ligature audit for Seacole ward.
- We inspected the seclusion room on Sunley ward. The seclusion room had a blind spot in the ensuite area. Cleaners caused the blind spots by accidentally moving the cameras. The provider reported this immediately to be rectified. Managers had ensured clean and well maintained environments on Sunley and Seacole wards. However, we noted that the carpet in some areas on Seacole ward was stained. We were unable to access all areas on Sunley ward due to a patient being unsettled.
- Staff displayed hand wash posters and hand sanitiser was available on the wards.

Safe staffing

- Managers did not ensure established staffing levels on all shifts. For Sunley ward, the provider reported established staffing rates of ten whole time equivalent qualified staff and 24 whole time equivalent unqualified staff. The provider reported vacancy rates of two qualified staff and 4.15 unqualified staff. For Seacole ward, the provider reported established staffing rates of ten whole time equivalent qualified staff and 24 whole time equivalent unqualified staff. The provider reported vacancy rates of four wholetime equivalent qualified staff and 7.14 unqualified staff.
- The provider used bureau (St Andrew's bank staff) and agency staff to fill vacant shifts. However, a number of shifts remained unfilled.
- The provider reported that 430 shifts out of 3,535 were unfilled for Sunley ward for the period 1 February 2018 to 30 June 2018. Of these, 97 out of 856 were unfilled qualified shifts and 311 out of 2,760 were unqualified. This equated to a fill rate of 89% for qualified staff and 88% for unqualified staff, against the provider's target of 90%.
- The provider reported that 304 out of 2,027 shifts were unfilled for Seacole ward for the period 1 February 2018 to 30 June 2018. Of these, 71 out of 794 were unfilled qualified shifts and 233 out of 1,233 were unqualified. This equated to a fill rate of 91% for qualified staff and 81% for unqualified, against the provider's target of 90%.
- The provider was recruiting to posts to meet the optimum staffing levels for each ward.
- Staff spoken with on Sunley ward told us that there would sometimes be only one qualified member of staff on shift and this could be an agency staff. Staff said there was a problem in getting agency staff for the ward. A newly appointed nurse, in their probation, took charge of the ward during part of the shifts they worked. Staff told us that most shifts ran short of staff. On the day of our visit we were told that 12 staff were due to be on duty. The shift had started with six staff on duty. Staff had contacted the duty manager who had arranged for an additional six staff to work on the ward. Staff told us that a few days previously they had run the shift on five staff and that this had happened approximately five times in the last ten months. Staff also told us that the duty manager was usually able to find more staff to help run shifts. The provider sent us copies of their staffing rotas but the details of which staff were on shift was not clear. To clarify staffing details, we requested further details of planned staffing and actual staffing for all shifts, however there were discrepancies between staffing information we found on the ward and the data sent by the provider.
- There were not always enough staff to provide the required level of patient observations. Sunley ward was fully occupied with 14 patients at the time of our visit. A minimum of five staff were required to provide enhanced observations of patients in day areas and

eight staff were required when patients were in isolated areas, for example, bedrooms. One patient required three staff to provide eyesight observations in the extra care area. Two patients required two staff to provide arm's length observations in isolated areas and one staff to provide this in day areas. Another patient required one staff to provide arm's length observations in isolated areas. Staff told us that one patient who was cared for by three staff, was nursed, during part of the morning shift, by two staff. There were eight staff on duty when there should have been 12. We reviewed an incident report related to there not being enough staff to provide a patient's required level of observations.

- There were not always enough staff to safely carry out physical interventions. We reviewed an incident where a patient required restraint to prevent an assault on staff. There were eight staff on duty when there should have been nine. Three staff were required to carry out enhanced observations. There were not enough staff to safely carry out the restraint and staff who intervened sustained injuries.
- We reviewed seven incident reports. Each report recorded the number of staff on duty at the time of the incident. For five incidents reviewed staffing was below the establishment level.

Assessing and managing risk to patients and staff

- Staff were assessing and managing risks to patients and staff. We reviewed four patient care and treatment records. Staff had completed risk assessments for all patients and reviewed these regularly. Staff used recognised risk assessment tools, for example, historical, clinical, risk management 20 (HCR-20) and short-term assessment of risk and treatability (START).
- The provider reported that 96% of staff on Sunley ward and 95% of staff on Seacole ward had completed Management of Actual and Potential Aggression training. Staff spoken with told us that they had completed this training.
- There were blanket restrictions on Sunley ward. Staff told us patients' snack times on the ward were 11am and 4pm. Staff did not allow patients to have snacks outside these times.
- The provider reported 295 restraint episodes on Sunley ward between 1 January 2018 and 30 June 2018. Of these, 95 were prone restraints and 90 resulted in the use of rapid tranquillisation medication. Prone restraint is a form of restraint where the patient is held in the chest down position.
- The provider reported 28 staff injuries in the same reporting period. Of these, 12 were sustained during episodes of restraint.
- Staff told us that they used arm hold restraints frequently for two patients on enhanced observations. Staff told us that prone restraint was used to administer rapid tranquillisation medication and exit seclusion.
- Staff did not always follow National Institute for Health and Care Excellence guidance for the use of rapid tranquillisation. Staff told us that rapid tranquillisation medication was administered most days. We reviewed one patient's records who had been administered rapid tranquillisation medication twice in one day. Staff had not completed the required physical health checks following both administrations.
- In the weeks prior to the inspection, the CQC conducted a review of seclusion and long-term segregation practice. We reviewed six seclusion records out 28 from 1 April 2018 to 30 June 2018 for Sunley ward. One patient was not reviewed by a doctor within the first hour of seclusion and one patient did not have the required four hourly medical reviews as outlined by the Mental Health Act Code of Practice. There were no internal multi-disciplinary reviews for those patients requiring one. Three of the six patients did not have seclusion care plans.
- We reviewed long term segregation for one patient in the forensic service. Long term segregation for one patient did not meet the Mental Health Act Code of Practice. Long term segregation is when a patient is separated from other patients and staff for the safety of themselves and others. The patient had been in long term segregation from May 2017 to the present time. We found that the care plan had only been updated once in June 2017. Multidisciplinary reviews were happening only monthly when the code required weekly multidisciplinary reviews. There was no evidence that 24 hourly reviews by an approved clinician had occurred or that independent clinical reviews had been completed. However, the provider informed us that they were entering into an agreement with an external provider to facilitate external reviews. The observation record for this patient was incomplete suggesting that there were times that this patient should have been observed but

was not. The patient was being segregated in the bedroom corridor during the day. If other patients wanted to access their bedroom the patient would move to the low stimulus area.

Track record on safety

- Sunley had reported ten serious incidents from 1 July 2017 to 31 May 2018. The most common were incidents of self-harm of which Sunley ward had six.
- There had been an unexpected death on Sunley ward within the last 12 months. We reviewed the incident report and case notes for this incident. The patient had up to date and detailed risk assessments and care plans completed. Learning from the incident had been shared across the provider's locations and with external mental health providers nationally. The providers serious incident investigation was ongoing.
- The ward had made changes following the incident to improve safety, including a review of contraband items and changes to assessing patients access to contraband items.

Reporting incidents and learning from when things go wrong

- The provider told us they shared learning from incidents via alerts sent by email and discussions in team meetings. However, staff spoken with told us that they would hear of incidents on other wards by word of mouth rather than through any formal means. We reviewed minutes of five team meetings and there was no learning from incidents discussed.
- We reviewed a further seven incidents on Sunley ward. Two related to staff shortages, two to physical aggression and violence, one to a staff injury, one to physical health and one to self-harm. The physical health incident related to a patient on a nasogastric feeding plan going without a nasogastric feed for a weekend. This incident occurred as there were no trained staff available to provide this intervention. Staff on duty took appropriate action to manage and escalate the incident. However, there was no evidence that this had been reported to the local safeguarding authority as an act of neglect or omission. We raised this with the provider during the inspection, they advised that they thought it had been reported and would follow this up.
- Staff told us that they received de briefs and support after serious incidents. This included visits from senior managers, support from the provider's trauma manager and free access to a confidential helpline.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- Staff ensured patient's needs were assessed and met within care plans. We reviewed four care and treatment records for patients. Staff had completed person centred and holistic care plans for three patients reviewed. Staff had completed full physical health assessments for all patients on admission and all had evidence of ongoing physical health care in their records.

Best practice in treatment and care

- Staff told us that patients had good access to physical healthcare when needed. A physical healthcare team, based on site, were available during the week to offer support with patients' physical healthcare needs. Staff could access emergency physical health care from the provider's emergency response teams and the local general hospital.

Skilled staff to deliver care

- Staff had not received the necessary specialist training for their roles. During our visit, two patients required nasogastric feeding. The ward manager was the only staff member trained to provide this intervention. Staff told us they had booked to attend this training with an external agency but the agency cancelled this at very short notice.

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

- A competent staff member examined patients' Mental Health Act papers on admission. Staff knew who their Mental Health Act administrators were and how to access them. The Mental Health Act administrators supported staff with renewals. Consent to treatment and appeals against detention.

Forensic inpatient/secure wards

- In most records, staff had provided patients with information about their legal position and rights, as required under section 132 of the Mental Health Act. However, on Sunley ward, we found that staff had not provided this information to a patient who was detained under section 3 on 19 July 2018. We noted the patient had been previously detained under section 5(2), though there was no evidence that staff had provided information to the patient about this section. In addition, staff had not provided this information to two patients, at the point of their section renewal in March 2018 and May 2018 respectively.

Are forensic inpatient/secure wards well-led?

Good governance

- Governance systems were not effective in ensuring shifts were covered by sufficient numbers of staff of the right grade and experience. We were not assured that the provider had systems to monitor the use of seclusion and long-term segregation to ensure they met the requirements of the Mental Health Act Code of Practice. Although the provider had reviewed their policy for seclusion and long-term segregation, we found that staff were not always clearly recording whether a patient was in seclusion or long-term segregation.

Leadership, morale and staff engagement

- Staff spoken with were aware of how to use the whistle-blowing process. Staff told us they felt able to raise concerns without fear of victimisation, although some staff said they did not always get a response to concerns raised.
- Staff were open and transparent with patients and explained if something went wrong.

Wards for people with learning disabilities or autism

Safe	
Effective	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

- The ward layout allowed staff to observe all parts of Spencer North and Sitwell wards. Blind spots were mitigated by the installation of mirrors.
- Managers had not ensured a safe environment. Whilst managers and the Health and Safety lead had completed ligature audits of Spencer North within the last 6 months, staff were not aware of where to find the audit. Some staff said they had never seen it and others told us that it was something the clinical nurse lead dealt with. We requested a copy from the provider and this was supplied during our visit.
- Spencer North and Sitwell wards had seclusion rooms. Sitwell seclusion room was compliant with the Mental Health Act Code of Practice. However, we noted that the ceiling of the seclusion room was stained.
- We were unable to check the seclusion room on Spencer North ward as it was occupied by a patient being cared for by staff under long-term segregation. The patient had personalised the seclusion room with their possessions. There was an ensuite, with shower, toilet and hand basin. Staff told us, if another patient required seclusion, they would be secluded on Spencer South ward or other wards within the hospital. Staff told us that this had impacted on other patients as it increased their distress if having to be transported to another ward for seclusion. Staff would also be taken off the ward to support the patient in seclusion.
- Managers had ensured clean and well maintained environments on Spencer North and Sitwell wards. However, there was no hand sanitiser in three dispensers checked on Spencer North ward.

Safe staffing

- Managers did not ensure established staffing levels on all shifts. For Sitwell ward, the provider reported established staffing rates of ten whole time equivalent qualified staff and 22 whole time equivalent unqualified staff. Staff in post as of end of June 2018 equated to six whole time equivalent qualified staff and 22.29 whole time equivalent unqualified staff. For Spencer North ward, the provider reported established staffing rates of ten whole time equivalent qualified staff and 14 whole time equivalent unqualified staff. The provider reported vacancy rates of 2.14 whole time equivalent qualified staff. The provider had over recruited by 9.44 whole time equivalent to unqualified staff posts.
- The provider used bureau (St Andrew's bank staff) and agency staff to fill vacant shifts. However, a number of shifts remained unfilled.
- The provider reported that 332 shifts out of 3,831 were unfilled for Sitwell ward for the period 1 February 2018 to 30 June 2018. Of these, 57 out of 717 were unfilled qualified shifts and 275 out of 3,114 were unqualified. This equated to a fill rate of 92% for qualified staff and 91% for unqualified, against the provider's target of 90%.
- The provider reported that 365 shifts out of 3,571 were unfilled for Spencer North ward for the period 1 February 2018 to 30 June 2018. Of these, 54 out of 811 were unfilled qualified shifts and 311 out of 2,760 were unqualified. This equated to a fill rate of 93% for qualified and 89% for unqualified.
- The provider was recruiting to posts to meet the optimum staffing levels for each ward.
- Staffing levels were as planned on the day of our visit for Spencer North (ten staff) and one under for Sitwell (ten staff on duty, 11 planned). The manager for Sitwell advised they could request additional staffing as required. Managers had delayed the admission of a patient recently to allow time to secure additional staffing resources. However, staff on Spencer North told us that there is not always enough staff. There was only one clinical nurse lead and two part time senior staff nurses. Managers were recruiting to these posts, but the workload was putting a lot of pressure on existing staff. Staff on Sitwell told us that they occasionally ran shifts on eight staff, although they would usually have ten.
- Staff raised concerns regarding the change to healthcare assistants delivering the food service as part of their

roles. Hotel service staff previously provided this support. Staff told us that they had not had additional healthcare assistants allocated to the ward to replace the loss of the hotel service staff. We were told it can take two staff up to four hours a day to provide the food service.
- A qualified nurse was present in communal areas of both wards during our visit.
- Staff told us that leave was rarely cancelled due to staff shortages.

Assessing and managing risk to patients and staff

- Staff did not always complete risk assessments for patients. We reviewed 12 patient care and treatment records, six on Spencer North and six on Sitwell. Staff had completed risk assessments for all patients on Sitwell and reviewed these regularly. However, staff had not completed up to date risk assessments for five patients on Spencer North.
- Staff used recognised risk assessment tools, for example, Historical, Clinical, Risk Management 20 (HCR-20) and Short-Term Assessment of Risk and Treatability (START).
- The provider reported that 100% of staff on Spencer North and 96% of staff on Sitwell had completed Management of Actual and Potential Aggression training. Staff spoken with told us that they had completed this training.
- We found no evidence of unnecessary blanket restrictions on Sitwell and Spencer North wards. Staff and patients told us they could request a snack or drink at any time.
- The provider reported 342 restraint episodes on Sitwell ward between 1 January 2018 and 30 June 2018. This was an increase from the last inspection in May 2017 when the provider reported 301 for the six months prior to the inspection. However, the use of prone restraint had reduced by 25% and there had been a 112% increase in patients being moved from prone restraint to the supine position. Of the 342 episodes, 35 were prone restraints and 11 resulted in the use of rapid tranquillisation medication. Prone restraint is a form of restraint where the patient is held in the chest down position.
- The provider reported 81 restraint episodes on Spencer North ward between 1 January 2018 and 30 June 2018. This was a significant reduction from the last inspection in May 2017 when the provider reported 233 for the six months prior to the inspection. Of the 81 episodes, 16 were prone restraints and eight resulted in the use of rapid tranquillisation medication.
- Staff told us that the use of physical restraint had reduced, although use could increase particularly with new patients. Staff said they would use de-escalation techniques before using physical restraint. Staff used prone restraint was to administer rapid tranquillisation medication and exit seclusion. This would be care planned and monitored through quality meetings. Staff told us that rapid tranquillisation medication was not administered very often.
- In the weeks prior to the inspection, the CQC conducted a review of seclusion and long-term segregation practice. We reviewed seven seclusion records out of 44 for Sitwell ward and five out of 14 for Spencer North from 1 April 2018 to 30 June 2018.
- On Sitwell, doctors had not reviewed one patient within the first hour of seclusion and two patients did not have continuing four hourly medical reviews as outlined by the Mental Health Act 1983 Code of Practice. Nurses had not completed the required two hourly reviews for one patient. Staff had not completed documented fifteen-minute observations for one patient. However, staff had completed seclusion care plans for all seven patients.
- On Spencer North, doctors had not reviewed two patients within the first hour of seclusion and three patients did not have continuing four hourly medical reviews as outlined by the Mental Health Act 1983 Code of Practice. Nurses had not completed the required two hourly reviews for two patients. There were no internal multi-disciplinary reviews for one patient. However, staff had completed seclusion care plans for four of the five patients.
- We conducted a review of long term segregation for two patients in the learning disability service. Long term segregation practices were not compliant with the Mental Health Act Code of Practice.
- For one patient, staff last facilitated an independent review on 28 February 2017. This was the only independent review that we could identify. An external hospital should carry out independent reviews of patients in long term segregation at least every three months. However, the provider informed us that they were entering into an agreement with an external provider to facilitate external reviews. We could not find

evidence that staff had sought the patient's or carers views when the long-term segregation was considered. An approved clinician had not formally reviewed the patient's situation in every 24-hour period. The multi-disciplinary team had not met every week to review the patient's long-term segregation. For example, after the multi-disciplinary team meeting of the 16 January 2018, the following documented one was the 6 March 2018.

- In the second record, staff had not completed treatment plans aiming to end the long-term segregation. Staff had completed long term segregation care plans dated 5 June 2017 and 5 May 2017. Staff on the ward confirmed that the care plan dated 5 June 2017 was the current one. An approved clinician had not formally reviewed the patient's situation in every 24-hour period. The multi-disciplinary team had not met every week to review the patient's long-term segregation. We could not find any evidence that staff informed the responsible commissioning authority of the outcome of the reviews that took place. It was not clear whether the ongoing risks had reduced sufficiently to allow the patient to be integrated into the ward. Staff had facilitated one external independent review, which was conducted by a covering responsible clinician. This took place on 21 June 2018 and the covering responsible clinician concluded that the long-term segregation should be terminated at the next multi-disciplinary meeting due to take place on the 22 June 2018. However, the multi-disciplinary team did not consider this. Staff were not sure of the difference between long-term segregation and seclusion. It was difficult to ascertain when the long-term segregation started as the progress notes documented it as seclusion. This was also raised by the covering responsible clinician who conducted the review on 21 June 2018.
- We reviewed an incident whereby a patient had been secluded in a corridor for almost four hours. Staff told us that they implemented the seclusion procedure as the patient was posing a risk to other patients and staff. Staff reported that they had been told not to seclude a patient in any area that was not a seclusion room. However, this would be difficult as the seclusion room was occupied with a patient nursed in long-term segregation.

Track record on safety

- Sitwell had reported seven serious incidents from 1 July 2017 to 31 May 2018. The most commonly occurring incident type related to physical health with two of the total.
- Spencer North had reported 11 serious incidents from 1 July 2017 to 31 May 2018. Five of these serious incidents related to allegations of abuse by staff. Safeguarding risks were managed appropriately and reported to the relevant agencies.
- There had been an unexpected death on Sitwell ward within the last 12 months. We reviewed the incident report and case notes for this incident. The patient had up to date and detailed risk assessments and care plans completed. Staff had not updated the patients' physical health assessment annually. However, there were regular GP referrals until January 2018 and a full nutritional screening in June 2017. The providers serious incident investigation was ongoing.
- The manager had implemented additional safety measures following a serious incident, which included ensuring staff with specific training were available to provide specialist support to patients.

Reporting incidents and learning from when things go wrong

- The provider told us they shared learning from incidents via alerts sent by email and discussions in team meetings. We reviewed weekly memos sent by managers to staff from 1 June 2018. However, whilst there was evidence of incidents on the ward being discussed there was no evidence of incidents from other wards or locations being discussed. We reviewed a further incident on Sitwell ward related to a near miss choking incident. Learning identified included ensuring regular staff were allocated to patient's observations during mealtimes.
- Staff told us that they received de briefs and support after serious incidents. This included visits from senior managers, support from the provider's trauma manager and free access to a confidential helpline.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Assessment of needs and planning of care

Wards for people with learning disabilities or autism

- Staff ensured most patient's needs were assessed and met within care plans. We reviewed 12 care and treatment records for patients, six for Sitwell and six for Spencer North. Staff had completed holistic, person centred and up to date care plans for all patients. Staff had completed full physical health assessments on admission for all six patients on Spencer North and for four patients on Sitwell. We found evidence of ongoing physical health care in all records on Sitwell and in five records on Spencer North.

Best practice in treatment and care

- Staff told us that patients had good access to physical healthcare when needed. A physical healthcare team, based on site, were available during the week to offer support with patients' physical healthcare needs. Staff could access emergency physical health care from the provider's emergency response teams and the local general hospital.
- Staff had completed a specialist care plan for a patient with dysphagia, with support from the speech and language therapy team. However, there had been an incident whereby staff gave the patient food of mixed consistencies and the patient choked. Staff administered backslaps and dislodged the food. Staff had not followed the care plan, which stated that food of mixed consistencies must not be given.

Skilled staff to deliver care

- Staff told us about specialist training they had received to support a transgender patient and to carry out assisted lifts. Staff had completed dysphagia training in December 2017. However, the provider had implemented refreshed dysphagia training following a death from a choking incident on another ward but we were told by staff that this training was not available to them as it was not a priority for this client group.
- Staff told us that they had completed 'reinforce appropriate, implode disruptive' training to support patients with learning disabilities.
- Staff told us they would receive bespoke training to meet individual patient needs. One example of this was training to support a patient with a serious eating disorder.

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

- A competent staff member examined patients' Mental Health Act papers on admission. Staff knew who their Mental Health Act administrators were and how to access them. The Mental Health Act administrators supported staff with renewals. Consent to treatment and appeals against detention. In most records, staff had provided patients with information about their legal position and rights, as required under section 132 of the Mental Health Act. However, on Sitwell ward, we found that two patients had been previously detained under section 5(2), prior to their current section. There was no evidence that staff had provided information to these patients about this section. Staff had not provided this information to three patients, at the point of their section renewal in October 2017, February and March 2018 respectively.
- On Spencer North ward, we found that staff had not provided this information to one patient for over six weeks from the point the patient was detained under section 3 in June 2018. Staff had not provided this information to one patient for over six weeks from the point they were transferred to the hospital in June 2018.

Are wards for people with learning disabilities or autism well-led?

Good governance

- We were not assured that the provider had systems to monitor the use of seclusion and long-term segregation to ensure they met the requirements of the Mental Health Act Code of Practice. Although the provider had reviewed their policy for seclusion and long-term segregation, we found that staff were not always clearly recording whether a patient was in seclusion or long-term segregation.

Leadership, morale and staff engagement

- Staff spoken with were aware of how to use the whistle-blowing process. Staff told us they felt able to raise concerns without fear of victimisation.
- Staff were open and transparent with patients and explained if something went wrong.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure sufficient staffing of the right grade and experience and with the required qualifications and training to provide safe care and treatment are deployed.
- The provider must ensure compliance with the Mental Health Act Code of Practice, including ensuring required seclusion reviews take place and the accurate recording of whether a patient is in seclusion or long-term segregation.
- The provider must ensure that staff are aware of environmental risk assessments and actions required to minimise identified ligature risks.
- The provider must ensure staff follow patient care and treatment plans.

Action the provider SHOULD take to improve

- The provider should review their governance processes to ensure improved monitoring of the service.
- The provider should ensure blind spots are identified and mitigated against.
- The provider should ensure that learning from incidents is shared with all staff.
- The provider should ensure that independent reviews of patients in long-term segregation take place.
- The provider should ensure that staff complete the required physical health checks for patients following the administration of rapid tranquillisation medication.
- The provider should review the use of blanket restrictions on Sunley ward.
- The provider should ensure that staff inform patients of their rights under section 132 of the Mental Health Act as required by the Code of Practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Managers did not ensure established staffing levels on all shifts. The provider reported that 1,698 shifts were unfilled for the period 2 February 2018 to 30 June 2018. There were not always enough staff to safely carry out physical interventions and provide the required level of patient observations on Sunley ward. • We reviewed incident reports relating to patient's observation levels being reduced and a patient self-harming when left unobserved due to staff shortages. • Staff were not trained to provide care to keep patients safe on Sunley ward. There had been an incident where there were no nasogastric trained staff available to administer nasogastric feeds to a patient requiring this intervention. Staff had not reported this to the local authority safeguarding team. • Staff had not followed the dysphagia care plan for one patient on Sitwell ward, which had resulted in a choking incident. • The provider was not compliant with the Mental Health Act Code of Practice. In the week prior to the inspection, the CQC conducted a review of seclusion and long-term segregation practices. We reviewed 22 seclusion records. Doctors and nurses were not completing reviews as required by the Mental Health Act Code of Practice. Staff had not completed seclusion and long-term segregation care plans for all patients. The multi-disciplinary team had not conducted reviews as required. Sunley and Bayley ward seclusion rooms had blind spots in the ensuite areas. • Managers had not ensured a safe environment at the learning disabilities service. Whilst the manager and the health and safety lead had completed ligature audits

This section is primarily information for the provider

Requirement notices

for Spencer North ward within the last six months, there was no hard copy of the ligature audit and assessment available. Staff on Spencer North did not know where to find the ligature audit.