

Avon and Wiltshire Mental Health Partnership NHS Trust

Forensic inpatient or secure wards

Inspection report

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Ratings

Overall rating for this service

Inspected but not rated ●

Are services safe?

Inspected but not rated ●

Are services effective?

Inspected but not rated ●

Our findings

Forensic inpatient or secure wards

Inspected but not rated



Fromeside is an 81 bed medium secure service caring for people with a mental illness and/or personality disorder who also have a criminal history or have risks and behaviours that mean they cannot be treated in mainstream mental health services.

We carried out this unannounced, focused inspection because we received information that gave us some cause for concerns about the safety and quality of the services. We visited five medium secure wards to assess the concerns identified. These centred on how the rights of these patients were respected and the continuity of care provided by staff and whether the service was able to consistently deliver specialist care and treatment to patients on enhanced levels of supervision with sufficient experienced and qualified staff. We also had reports that the environment was not adequate for all patients whose care, at times, had to be delivered away from the wards in seclusion or long-term segregation due to a number of risks.

The service is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the 1983 Act.
- Treatment of disease, disorder or injury.

During the inspection we looked at relevant key lines of enquiry from the key questions, 'are services safe and effective'.

We did not rate the service during this inspection. The previous rating of good remains.

We found:

- The service provided safe care. The ward environments were safe and clean although we saw one seclusion suite that needed repair. Managers said staffing levels were maintained with regular bank and agency staff. Staff assessed and managed risk well. Steps were being taken to minimise the use of restrictive practices. Staff managed medicines safely and followed good practice with respect to safeguarding patients.
- Staff developed care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards.
- Staff planned and managed discharges and liaised with services that would provide aftercare.

However,

- Multidisciplinary teams did not always work well together, and communication was poor between some medical staff and nursing staff.

Our findings

- Staffing levels were maintained by regular bank and agency staff due to vacancies, although recruitment was in progress
- There were a few care plans that lacked guidance to staff on how patient's needs were met in their preferred manner. Managers had recognised this, and action plans were in place to improve care planning procedures.
- Some records including mental capacity assessments and details of whether patient's rights had been explained to them on a regular basis when detained under the Mental Health Act were not always kept in care files.
- A few reports of the debriefs undertaken with staff were not documented following incidents

How we carried out the inspection

We conducted an unannounced focused inspection looking at specific areas of two key questions:

- Is it safe
- Is it effective?

During this inspection, the inspection team visited Laden Brook, Wellow, Severn, Teign and Cary and spoke with

- Clinical manager and clinical lead
- Two modern matrons
- The acting quality improvement manager
- Three ward managers
- Eight ward staff, including nurses and healthcare support workers.
- Three patients during the site visit and three patients remotely
- Three relatives
- Nine care and treatment records and 11 medicine records
- A range of policies, procedures and other documents relating to the running of the ward.

You can find further information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Is the service safe?

Inspected but not rated



- Patients across all wards we spoke with felt safe and they said staff made them feel safe. The staff attended annual training in safeguarding adults and knew their responsibilities to report abuse. They were knowledgeable about reporting any poor practice witnessed towards patients by other staff or abuse by other patients.
- Staff assessed patients' individual risks and developed management plans to minimise them. Patients we spoke with knew their individual risks and plans of care on how staff supported them with taking positive risks. For example, preparing meals and progressing to unescorted leave.

Our findings

- There were patients whose complexities of behaviours at times placed them and others at potential risk of harm. Plans were developed and reviewed on how staff supported these patients when behaviours that challenged them were presented. Some patients, due to the levels of risk when their behaviours escalated, spent time away from others in seclusion and long-term segregation.
- Patients we spoke with about how they expressed their anxieties and frustrations told us regular staff managed these incidents well.
- Staff had easy access to clinical information and were kept informed about patients' changing needs through daily handovers.
- Care environments were risk assessed annually or as needed which included specific ligature assessments. The ward layouts allowed all parts of the ward to be observed. There were clear lines of sight and no blind spots. Rooms where risks were present such as the activity room or kitchen were always kept locked and when in use, always had a staff presence.
- The service used systems and processes to safely prescribe, administer, record and store medicines. People knew the purpose of their medicines and where appropriate they were supported to self-administer these.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- Patients generally received consistent care and support from regular staff including agency and bank staff. The service was making every effort to ensure staffing levels were maintained, and the service was taking steps to recruit to vacant posts and develop the skills of existing staff.

However:

- There were several permanent staff vacancies. Patients told us where staff were not regular there was a lack of continuity. Managers described the issues with retaining skilled staff to support patients when there was an escalation of complex behaviours which required enhanced levels of supervision.
- Some staff gave us negative feedback about the culture between staff teams. Staff said that in some wards the attitudes towards some members of the team was not always in line with the organisational values of respect and integrity. Managers were assigned with lead roles in this area and they told us about the systems in place and the progress made towards improving cultures between staff. The systems for improving the culture were in the early stages and were not fully embedded yet.
- Managers had identified there were areas of the environment in need of repair. Although repairs to a seclusion suite had been identified this remained outstanding and there was no identified timescale for the repairs.

Is the service effective?

Inspected but not rated



- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Bradley Brook ward was part of the National Reducing Restrictive Practice (RRP) project which included reducing the use of restraint, seclusion, and rapid tranquilisation. The reports of the internal analysis concluded that there had been a reduction of restrictive practice once key learning had been introduced.

Our findings

- Patients we spoke with understood the reasons for their admissions and the conditions of their stay. Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.
- Some staff and managers including a senior manager told us that while the level of care delivered was of a good standard, the quality of the care plans was an area that they needed to improve. During the inspection we saw examples of skilled care being delivered to patients and when we observed staff we saw kind and understanding interactions.
- Senior managers had recognised communication between teams was an area for improvement and had assigned lead roles to develop care pathways on improving communication.
- Patients knew their rights and told us about the day to day decisions they made such as making refreshments and what they wore. They said staff kept them informed about their rights and they understood the long-term decisions about their care and treatment.

However:

- There were a few care plans that were not personalised and lacked guidance on how staff were to meet patient's needs. The quality of some care plans and risk assessments was inconsistent and the level of detail varied from one document to another. One care plan lacked input from the patient into the planning of their care and on how staff were to support them to meet their needs.
- From some interaction we observed it was clear that some of the working relationships were not always positive or effective. We were present during a discussion between staff about a transfer within the hospital and witnessed a lack of effective communication between some consultants and ward staff. Staff told us that some consultants made decisions without input from the multidisciplinary teams. A relative also told us consultant appointments were not happening as arranged and they were not kept informed about decisions made on behalf of their family member
- Staff did not ensure that mental capacity assessments and regular explanation of patients' rights were documented in all care records for four patients.
- Although we were told that the service could cater for people's dietary requirements, that menus were devised in advance and that there was a choice of two meals at each mealtime, patients told us that food menus were repetitive and lacked variety. Although they were asked about their dietary requirements these were often not met due to either not enough food or poor choice and quality of food. Most wards provided additional food that they had bought from local shops. Staff and patients cooked food that they had bought from local shops to provide a more nutritious and varied diet for patients.

Our findings

Areas for improvement

The trust should ensure that

- the service continues to improve the quality of care plans by ensuring they are person centred and provide sufficient guidance for staff to meet people's care needs.
- the service continues to develop relationships and foster a positive culture between teams.
- the service records include patient's awareness of their rights under the Mental Health Act on a regular basis and that mental capacity assessments are available in care records.
- the service makes the required environmental improvements needed in the seclusion suites without delay.
- the service continues with the recruitment of staff to ensure it can deliver continuity of care to patients.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two inspection managers, a Mental Health Act reviewer, the head of inspection, a specialist advisor and an Expert by Experience. The specialist advisor was a nurse with experience of working in mental health wards. An Expert by Experience is a person who has personal experience of using or caring for someone in this type of care service.