St Andrew's Healthcare

St Andrews Healthcare Northampton

Inspection report

Billing Road
Northampton
NN1 5DG
Tel: 01604616000
www.stah.org

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

St Andrews Healthcare is an independent organisation that provides mental health care across three sites in England. We visited the Northampton site to check on the quality of care provided.

Urgent enforcement action was taken following the inspection in July and August 2021 because of immediate concerns we had about the safety of patients on the forensic inpatient or secure wards, long stay or rehabilitation mental health wards for working age adults and wards for people with learning disabilities or autism.

We imposed conditions on the provider's registration that included the following requirements:

- the provider must not admit any new patients without permission from the CQC;
- wards must be staffed with the required numbers of suitably skilled staff to meet patients' needs;
- staff undertaking patient observations must do so in line with the provider's policy;
- staff must receive required training for their role and that audits of incident reporting are completed.

Following the previous inspection, we wrote to the provider on 9 May 2022, to vary one condition to allow, from 10 May 2022, that St Andrews Healthcare Women's service could admit up to a maximum of 1 patient per week to each ward without seeking permission from the Commission. The admissions could not be carried over to following weeks should an admission not occur. All other conditions outlined in the section 31 notice of decision from July 2021 remained applicable. The provider was required to provide CQC with an update relating to these conditions on a fortnightly basis.

This inspection was a focussed inspection of the wards that had conditions attached to see if improvements had been made. We found that sufficient progress had been made and that the conditions could be removed. This service has been removed from special measures due to the improvements we found.

Previous inspections have produced 2 reports: one for the Women's service and one for the Men's service. Following the provider re-registering as single site, we have completed a single inspection report.

Our rating of this service improved. We rated it as requires improvement because:

- Easy read information was not available on Church ward for patients who may have required it so they could fully understand their care and treatment.
- Staff undertook physical observations following periods of rapid tranquilisation although they were not consistently recorded in the same place within the patient care record.
- Not all medical devices and equipment was maintained in line with the supplier's guidance and was not appropriately recorded.
- Medicines management processes were not always adhered to in line with the provider's policy and procedures.
- Not all health care assistants thought their safeguarding training was sufficient.
- Compliance for safety intervention training was lower than required across all the wards. Not all staff on Bracken and Maple ward were up to date with basic life support training.
- Staff on the Men's wards did not always plan shifts effectively. Often, staff carried out enhanced observations one after the other without any break in between.
- Staff on the Men's wards did not always receive regular clinical supervision in line with provider's policy.
- Governance processes did not always work effectively to ensure good oversight of quality and performance data to ensure that ward procedures ran smoothly.

Summary of findings

- Staff on the Men's wards did not always feel as though they were respected, valued and supported.

However:

- The service had made sufficient improvements in relation to the conditions applied at the last inspection so we removed them and took them out of special measures.
- The service provided safe care. The ward environments were generally safe, clean and appropriately risk assessed.
- Staffing had improved. The service had sufficient, appropriately skilled staff to meet patient's needs and keep them safe. Patients were able to access escorted leave when they wanted to, and there was a wide range of readily accessible activities.
- Training compliance had improved for most required training, and most staff received regular supervision on the Women's wards. Staff were provided with sufficient information to ensure patients were kept safe.
- Staff assessed and managed risk well. Staff undertook patient observations in line with the provider's policy and had a good awareness of individual patient's risks.
- Staff followed good practice with respect to safeguarding and recognised abuse, reporting concerns appropriately.
- Incident reporting and record keeping had improved. Staff knew what incidents to report, how to report them, and they were recorded appropriately in the patient care record and the incident reporting system.
- Culture on the wards had improved and the provider had introduced a number of approaches to prevent an occurrence of a closed culture.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to St Andrews Healthcare Northampton

St Andrew's Healthcare has been registered with the CQC since 11 April 2011. The service has a nominated individual as required, and a controlled drugs accountable officer. At the time of the inspection, the provider had applied to change its registration with the Care Quality Commission to 1 location instead of multiple registrations across one site. In August 2023, CQC agreed to the change to the registration. Therefore, we have produced 1 single report for what was previously the Women's and the Men's services.

St Andrew's Healthcare is registered to provide the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983.

• Treatment of disease, disorder or injury.

This location has been inspected 11 times. The most recent comprehensive inspection was in April to June 2022.

The Women's service was rated as requires improvement overall. The forensic inpatient/secure wards were rated inadequate overall and wards for people with learning disability/autism were rated as requires improvement. The Men's service was rated as requires improvement overall. At this inspection we inspected under the core service of forensic inpatient/secure wards only. Due to differences in current ratings across the wards, we will report on findings based on an overall previous rating of inadequate in safe and requires improvement in well led.

We undertook an unannounced focused inspection to check that improvements had been made against the conditions imposed on particular wards within the service under the following key questions:

• Are services safe?

• Are services well-led?

We visited 8 wards:

Five women's wards:

Oak is a 10 bedded ward that provides care for people with learning disabilities in a medium secure setting.

Church is a 10 bedded ward that provides care for people with learning disabilities in a low secure setting.

Maple is a 10 bedded ward that provides care for people with a mental health illness in a blended low and medium secure setting.

Bracken is a 10 bedded ward that provides care for people with a mental health illness in a medium secure setting.

Willow is 10 bedded ward that provides care for people with a mental illness in a blended low and medium secure setting.

Summary of this inspection

Three men's wards:

Sunley ward is a 15 bedded ward that providers care for people with learning disabilities in a low secure setting.

Meadow ward is a 10 bedded ward that provides care for people with learning disabilities in a medium secure setting.

Mackaness is a 15 bedded ward that provides care for people with a mental illness in a medium secure setting. Following a MHA review visit to Mackaness ward on 19 June 2023, we were made aware of an incident that occurred on Mackaness ward on 14 June 2023. At that time we had not received a notification for the incident. It was reported that on the 14 June 2023 and during the evening shift 5 patients were able to access the nursing office shouting abuse with the intention of getting to another patient who was being nursed in the extra care suite, that could be accessed from the back of the nursing office.

Based on this information we included a visit to Mackaness ward as part of this inspection. The focus for visiting Mackaness ward was to follow up on the reported incident. Following this visit, speaking to the ward manager and staff and patients involved in the incident and reviewing various documents relating to the incident. We felt assured that the incident had been recorded and investigated correctly and a notification was in the process of being sent to CQC. Managers had identified the root cause for the incident and put in place measures to prevent a similar thing happening again.

What people who use the service say

We spoke with 15 patients across the women's service.

Patients were positive about the support they received. They said they felt safe, staff were helpful and caring. There were activities available and they could speak with staff when they had concerns. Patients were working together on their treatment and discharge plans with the multi-disciplinary team and appreciated this collaborative working.

We spoke with 5 patients across both Sunley and Meadow wards.

Four patients told us that the wards are always short staffed and 1 patient said that this sometimes impacts the range of activities offered, whilst another said that staff from other wards come to cover and they do not know the patients.

Four patients said they like the staff and are happy on the ward.

Four patients said they like activities that are offered, visiting the café and having escorted leave to go into the town.

One patient told us they felt the ward was too restrictive with regard to observation levels and the use of mobile phones.

How we carried out this inspection

This was an unannounced inspection to see how the provider had improved the service since our previous inspections. During the inspection we:

- visited all 5 women's and 2 men's wards that we imposed conditions on at previous inspections
- reviewed the quality of the environments and observed how staff were caring for patients

Summary of this inspection

- spoke with 20 patients who were using the service
- spoke with 27 staff members
- reviewed 24 patients care and treatment records
- reviewed 38 medicine prescription cards
- attended 2 multi-disciplinary team meetings, 1 risk morning meeting.
- reviewed a range of policies, procedures and other documents relating to the running of the service.

You can find 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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure that patients have access to easy read information when required so they can fully understand their care and treatment. (Regulation 9 (3)(g))
- The provider must ensure that physical observations are consistently recorded within the patient care record. (Regulation 12 (2)(b))
- The provider must ensure that e-observations are entered in real time to ensure patient safety. (Regulation 12(2)a))
- The provider must ensure staff effectively plan shifts so they do not carry out enhanced observations one after the other. (Regulation 12(2)b)
- The provider must ensure that staff are aware of systems in place to check emergency equipment and other clinic room equipment is checked and audited to ensure it is not out of date. (Regulation 12(2)(e))
- The provider must ensure that medicines management processes are fully adhered to in line with the provider's policies and procedures. (Regulation 12 (2)(g))
- The provider must ensure that they have robust governance processes in place to ensure the monitoring and oversight of training, supervision, observations and equipment and have a robust audit programme in place to address any compliance issues. (Regulation 17(1))
- The provider must ensure that staff are fully compliant with their training needs, including safeguarding training. (Regulation 18(2)(a))
- The provider must ensure there are robust processes in place to ensure that staff receive regular clinical supervision. (Regulation 18(2)a))
- The provider must ensure that all wards have sufficient qualified nurses to meet their establishment on night shifts. (Regulation 18 (1))

Action the service SHOULD take to improve:

- The provider should ensure that safeguarding training is sufficient for health care assistants. (Regulation 12)
- The provider should consider carrying out drills for the emergency bag on Meadow ward. (Regulation 12)
- The provider should ensure that T2 and T3 forms are completed appropriately. (Regulation 12)
- The provider should ensure that all staff are aware of who is trained in safety intervention training. (Regulation 12)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Requires Improvement

Forensic inpatient or secure wards

Safe	Requires Improvement
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

Most wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Across both services, staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards by placement of staff and by the use of convex mirrors. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe with risk assessment and management plans. Managers had completed ligature risk assessments for each ward.

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

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff carried personal alarms and each ward had a bleep holder who would respond when an alarm was raised.

Maintenance, cleanliness, and infection control

Ward areas were generally clean, well maintained, well-furnished and fit for purpose. Regular audits highlighted any areas of concern. In the Women's service, one en-suite toilet on Church ward was not visibly clean. Most wards were appropriately decorated, with positive, welcoming environments, although Church ward was bare, barren, and not stimulating.

Church ward had 2 chairs in the lounge that required replacing, and the washing machine was broken. We were told there were plans for the ward to move to a new location which meant that the environment would improve.

Since our previous inspection of the Men's service, Sunley ward had been redecorated and painted and there were no concerns with any fixtures or fittings. However, there was a damp smell on the entrance to the ward but staff told us the carpet was due to be changed, along with removing carpet in patient bedrooms the weekend following our visit. We found the communal bathroom on Meadow ward had a number of items of storage located inside and would not be able to be used as a bathroom. The ward manager told us these were patient items that were there due to the patient moving

Staff made sure cleaning records were up-to-date and the premises were generally clean. Staff followed infection control policy, including handwashing.

Requires Improvement

Forensic inpatient or secure wards

Seclusion room

Seclusion rooms on the Women's wards allowed clear observation and two-way communication. They had a toilet and a clock.

On the Men's wards, the Sunley seclusion room allowed for clear observation of the patient and there were monitors for observation. Two-way communication was available and there was a separate bathroom with a toilet and a shower for patient use. There was a clock visible to the patient at all times and lighting settings were available to change the colour of the room. The seclusion door did not have a hatch to pass food, drinks or medication through to the patient.

There was 1 seclusion room for Meadow ward and 1 for another ward which were located on a shared corridor. There was two-way communication available and a separate bathroom with a toilet and shower for patient use. A clock was visible. Both seclusion room doors had a hatch to pass food, drinks or medication to the patient.

Clinic room and equipment

Clinic rooms were fully equipped, with emergency drugs but not all had accessible resuscitation equipment. Across the Women's service, on Church ward not all staff were aware of the system to regularly check emergency equipment. An oxygen cylinder was out of date, although was replaced quickly when we told staff about it.

Maintenance and calibration records were in place for most medical devices, however there were a number of items which were out of date or records were missing. Bracken ward clinic had a faulty fridge which had been reported in April 2023 and was awaiting replacement at the time of inspection.

On the men's wards, staff did not always check or maintain equipment. On Sunley ward we found that there were 98 vacutainer bottles and an oxygen mask and tubing that were out of date. These were removed immediately by ward staff when raised at the time of our visit.

Meadow ward did not have a sign on the clinic room door to indicate that there was oxygen stored in the room.

There was no emergency equipment on Meadow ward. In case of an emergency staff would need to access emergency equipment from Fern ward. The ward performed drills and scenario testing to ensure emergency equipment could be transported in a timely manner.

Safe staffing

The service did not always have enough nursing staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

At the previous inspection, we found that there were not enough suitably skilled staff to meet the needs of the patients. At this inspection, we found that this had improved. However, the service did not always have enough nursing staff.

Across the Women's service, staffing figures between 5 June and 2 July 2023 showed that wards had mostly met their expected staffing requirements.

Requires Improvement

Forensic inpatient or secure wards

Qualified nurse shifts for days were 93% filled and 80% filled for nights. However, the wards were established for 2 qualified nurses on night shifts, and often only had 1 qualified nurse. Willow ward had the highest shortfall of qualified nurses on nights at only 46% filled shifts. Church ward was overfilled at 107%. Managers and staff mitigated this by ensuring the night co-ordinator and extra healthcare assistants were available when required. Qualified staff from other wards were also moved to ensure gaps were covered.

Healthcare assistant shifts were overfilled at 125% for both days and nights. This meant that extra staff were available and mitigated against any short fall of qualified nurses. Staff told us that staffing had improved, although there were some shifts that were short of 1 or 2 staff. Staff ensured patients were safe, but at times had to miss a break.

Across the Men's service, we reviewed staff fill rates from 5 June to 2 July 2023 and found that on Meadow ward there was a 104% fill rate for qualified nurses on the day shift and a 136% fill rate for healthcare assistants. During the night shifts there was a fill rate of 103% for qualified nurses and a fill rate of 167% for healthcare assistants. For Sunley ward there was a 109% fill rate for qualified nurses in the day shift and a 106% fill rate for healthcare assistants. During the night shifts there was a fill rate of 102% for qualified nurses and a fill rate of 87% for healthcare assistants staff. The wards were established for 2 qualified nurses on the day shift and 1 qualified for the night shift. However, staff on Sunley ward told us they did not always have a break during their shift and were, at times, unable to leave observations or the ward to take physical health medication or eat food, due to staff shortages. The service informed us there was a missed breaks escalation procedure in place to try to facilitate break cover or ensure that time off in lieu is approved through the appropriate process. There were no vacancies for qualified nursing staff and healthcare assistants on the men's wards.

The Women's service had reducing vacancy rates. Church ward and Oak ward were over established therefore did not have any vacancies. Bracken and Willow ward had qualified nurse vacancies at 4.3 and 0.7 respectively. Willow ward had 5 vacancies for healthcare assistants.

Managers across all the wards used bank and agency staff and requested staff familiar with the service. Most bank and agency staff worked night shifts. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Across the Women's services, we reviewed bank and agency staff usage from 9 June to 7 July 2023. Willow ward used agency staff, internal bank staff or overtime on 76% of shifts; 34% were agency, 35% internal bank and 31% overtime. For the same period Maple used agency staff, internal bank staff or overtime on 52% of shifts; 17% agency, 34% internal bank and 48% overtime. Bracken used agency staff, internal bank or overtime on 75% of shifts; 32% agency, internal bank 39% and 29% overtime. Church used agency staff, internal bank or overtime on 91% of shifts; 31% agency, 54% internal bank and 22% overtime. Oak used agency staff, internal bank or overtime on 60% of shifts; 52% agency, 47% internal bank and 47% overtime.

Across the Men's services for the same period, there were 35 shifts (21%) where agency staff were used, 57 (34%) where staff from the internal bank system were used and 76 shifts (45%) that were worked as overtime. For the same period on Sunley ward, there were 12 shifts (7%) where agency staff were used, 46 shifts (27%) where staff from the internal bank were used and 77 shifts (46%) that were worked as overtime.

Managers supported staff who needed time off for ill health and worked in conjunction with human resources to support those who had been off long term. Sickness rates between April 2023 to June 2023 for the Women's wards showed Willow ward had the highest sickness rate at 13%. Maple and Oak had the lowest sickness rate at 5%. Across the Men's service, Sunley had an overall sickness rate for that period of 9% and Meadow of 7%.

Requires Improvement

Forensic inpatient or secure wards

Across both services, managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift and the ward manager could adjust staffing levels according to the needs of the patients. Staffing was discussed in morning risk meetings. Requests for extra staff were made through the quality matron and general manager for that service. This meant that staffing across the service could be reviewed and staff moved to areas that required extra support or wards which were short of staff. This had been a recent change to the procedure and not all ward managers we spoke with liked the new system. They felt it was more time consuming and took away some of their control, such as requesting staff who they knew well and were familiar with the ward and patients.

At our previous inspection, we found that patients were not always able to take their escorted leave or activities were cancelled when the wards were short staffed. At this inspection, we found that this had improved. We reviewed planned Section 17 leave taken against actual Section 17 taken for the wards we inspected from 19 June to 2 July 2023. We saw that planned leave was taken on most occasions and all wards had also facilitated unplanned leave. Leave was planned in advance and allocated on the ward's daily planner.

During our visit we observed patients utilising their section 17 leave both in the community and the café on site and observed a sensory circuits session taking place.

When reviewing patient records on the Men's wards, we could see that patients meaningful activity was recorded, including when leave or activities were offered and when the patient declined to engage. From 19 June to 2 July 2023 there were 24.7 hours of planned leave on Meadow ward and an additional 72.7 hours were taken, totalling 104.8 hours of section 17 leave. On Sunley ward there were 29.75 hours of planned leave and an additional 74.5 hours of leave were taken, totalling 103.5 hours of leave. Staff from both wards also told us the service were in the process of recruiting technical instructors for each ward.

We reviewed 16 patient care records across the 5 Women's wards. We found 1 incident on Oak ward when leave was not taken due to staffing levels. One patient told us of 2 occasions when they could not go on leave. The ward manager on Church ward said there had been times when leave had been cancelled in the past however this had been because the patient had been unwell.

We found that activities were offered and taken across all the wards inspected. Patients had individual activity timetables and there were enough activity workers who were supervised by the occupational therapists. Activities for each patient would depend on their level of illness, associated risks, and the type of ward they were admitted to. On the day of our inspection, 5 patients from one of the Women's wards, Maple, had gone on a day trip to Skegness. Typical activities consisted of swimming, summer gel nails, café club, coffee mornings, and education.

There were 4 occupational therapist vacancies across the Women's service which were being recruited to.

Across both services, and as part of the provider's new Thrive programme, staff from the multi-disciplinary team such as occupational therapists, technical instructors, peer support workers and assistant psychologists were rostered onto shifts. The aim was to increase therapeutic activities for patients and reduce incidents.

Staff on Church ward, which was part of the Women's service did not always document 'meaningful activity' within the patient care record. The ward had prioritised improving staffing levels and culture, and the ward had been without an activity worker, so staff had not focussed on providing many activities. However, recently patients had been involved in creating a new activity timetable with the newly appointed activity worker.

Requires Improvement

Forensic inpatient or secure wards

Both services had enough staff on each shift to carry out any physical interventions safely. However, some staff told us due to the volume of new starters over the previous 6 months, this impacted on staff not being fully trained and able to support any physical interventions required. No incidents had taken place as a result of this in the previous 6 months.

The service had enough staff to carry out physical health monitoring. We reviewed 24 patient care records across both services and could see patients received regular physical health monitoring. Patients with specific physical health issues had care plans in place and staff completed physical health checks such as fluid balance charts, National Early Warning Score 2 (NEWS2), neurological and physical health observations. Where patients had specific physical health conditions such as diabetes or epilepsy, there were specific care plans in place to monitor and support this. Staff escalated concerns when patients became physically unwell and liaised with the physical health team who promptly provided advice and input.

Staff had completed neurological observations following an incidence of head banging. Staff also completed non-contact physical observations if a patient refused observations which was good practice.

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

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover and made sure they had a full induction and understood the service before starting their shift.

Mandatory training

At our previous inspection, we found staff had not kept up to date with some of their mandatory training. At this inspection, we found that this had improved, however, there were still areas requiring improvement.

Across the Women's service, overall compliance for the Women's wards ranged from 87% to 93%. Staff on Bracken and Maple wards were below compliance for basic life support at 67% and 63% respectively. All wards were below compliance for safety intervention training (SIT); the lowest was Oak at 70% and the highest was Bracken at 78%.

Across the Men's services, overall compliance for the Men's wards was 75% for Sunley and 89% for Meadow. Staff on both wards were below compliance for SIT and The Oliver McGowan Mandatory Training on Learning Disability and Autism. Sunley was 64% and Meadow was 77% for SIT and 51% and 76% for The Oliver McGowan training. Sunley ward was only 56% compliant for immediate life support. The service informed us that specific sessions for safety intervention training were taking place weekly on Sunley ward to increase compliance.

We were told there had been a high number of new starters on Meadow ward which had provided a challenge to ensure training compliance was up to date. The service told us that extra training sessions had been put in place by the learning and development team to support completion of mandatory training.

Many of the new starters had not been able to access SIT training yet. We were told additional sessions had been scheduled for the 2 months following our inspection to ensure full compliance.

Staff said they were aware of which staff on each shift had not received SIT training, and skill mix was checked across all shifts. However, staff on Bracken ward were unsure about the upcoming night shift because all the staff were agency staff and bank staff.

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. The service told us that from October 2023, a new training model will be introduced to ease the way staff can be released to attend training, whereby staff will receive all their mandatory training during a one-week period. This will allow wards to plan more easily and ensure staff can be released as they will be rostered out for the whole week and will have less impact on clinical care.

Staff on the Men's wards did not always receive clinical supervision regularly. In June 2023, only 14% of staff on Sunley ward had received clinical supervision. On Meadow ward, 81% of staff had received clinical supervision for the same period. The service explained the low level of supervision on Sunley ward due to a lack of staff in leadership positions on the ward due to staff suspension and the implementation of a new ward leadership team to drive compliance.

Assessing and managing risk to patients and staff

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

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 24 risk assessments and management plans. They were reviewed and updated during multi-disciplinary team meetings. Staff also completed specific risk assessments as required, for example, the HCR-20 V3, which is a 20-item structured clinical guide for the assessment of violence risk.

Management of patient risk

We reviewed 24 patient care records across both services. Staff knew about any risks to each patient and acted to prevent or reduce risks. Individualised care plans were in place to manage identified risks. There were specific care plans in place in order to manage patient risks for example vaping, self-harm and pornographic materials and sex aids. Patients had a positive behavioural support (PBS) plan in place which identified risk factors, triggers, and warning signs and how best to individually manage these based on the patient's preferences. Staff received training in PBS. All staff were above 92% compliant.

Staff had easy access to patient grab sheets which included patient risks and how to manage them. On the Women's service, staff on Maple ward had reduced patient risk by ensuring they could effectively communicate with deaf patients by using British sign language.

Staff across both services reviewed patient observations at regular intervals or when the patient risk had changed. Patient observations were discussed in daily risk meetings and were recorded in the electronic patient care record within the nursing notes so all staff were aware.

At our previous inspection, we found that staff did not always undertake patient observations in line with the provider's engagement and observation policy. At this inspection, we found that this had improved. On the Women's wards, we

reviewed 29 enhanced observations records over a period of 24 hours or longer and 1 for a period of 5 days. There were 4 occasions where an observation had been missed and 6 where they were recorded a minute or 2 late. Managers had a good oversight of missed or late observations and were discussed in daily risk meetings or with individual staff when necessary.

Data sent by the provider for the Men's wards stated that on 96% (132) of occasions, staff had been undertaking enhanced support for less than 2 hours and of the 5 incidents when they had been doing observations or providing support for greater than this period, none reported that they had not been offered a comfort break. There were no occasions where staff did not know or were not following the support plan or where observation paperwork was not accurately completed. During our inspection we reviewed the shift planners for each inspection day and found that staff would rotate from one set of enhanced observations to another. For example, on Sunley ward on 4 July 2023, one staff member was on a three to one observation for 2 hours, followed by a one-to-one observation for 2 hours and then was back on the three to one observation, totalling 6 hours continuously on enhanced patient observations.

On the Men's wards, we reviewed 17 24-hour e-observations on the patient record system. There was a total of 394 observations. Of those, 64 (16%) were late, 12 (3%) had not been entered at the point of review and 318 (80%) had been completed on time. Of those that were late, they were all less than 5 minutes late.

Most staff said they received their break whilst on patient observations, however some said they did not. The provider had a process in place for this for escalation, and staff were able to claim time owing in lieu for this.

The provider's detailed patient observation dashboard showed that compliance of observation levels had significantly improved over the last year. Senior managers reviewed and scrutinised the data to ensure wards were improving and staff were compliant with the provider's enhanced observation policy.

Staff identified and responded to any changes in risks to, or posed by, patients. Ward managers from both services attended daily morning risk meetings to discuss incidents, safeguarding concerns and other immediate patients concerns and risks, and acted accordingly. On the Men's service, the ward manager on Meadow ward explained that there had been a higher number of incidents involving one patient. The ward were in the process of reviewing the patient dynamics in a response to this to reduce incidents and level of risk.

Across all the wards, staff followed procedures to minimise risks where they could not easily observe patients. This was achieved by placement of staff, concave mirrors, and CCTV, although this was only reviewed if required, such as after an incident.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Searches were carried out on an individual basis depending on the risk presented.

Use of restrictive interventions

Levels of restrictive interventions were reducing. On the Women's service, staff on Bracken, Willow and Maple wards promoted positive risk taking, and worked proactively with patients to manage risks across the ward. Staff had open discussions with patients about what restrictions needed to be in place across the ward, which could change, dependant on risks the current patient cohort were displaying. Restrictive practices and expectations on the ward were discussed in community meetings and daily with individual patients. There was an individualised approach to restrictions and transparency with patients about risks and restrictions, had helped see a reduction in levels of incidents, restraints, and seclusions.

Staff could attend reflective practice sessions which helped them consider alternative ways to manage individual patients. Staff said these sessions were useful and helped them with their decision making.

Staff on Church ward discussed restrictive practice with patients in community meetings. Patients and staff worked together to ensure any restrictions were kept to a minimum.

All the wards, participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff were trained in providing least restrictive practice. All wards were over 85% compliant.

Staff from both services made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. This was reflected in patient care records and incident data. Staff said they used patients' PBS plans to reduce the level of incidents and restraint. Data from July 2022 to July 2023 for some of the Women's wards, Bracken, Willow, and Maple, showed a decline in the level of restraints. Between July and December 2022 there had been 106 patient restraints; between January 2023 to June 2023 there had been 21. This was a reduction of 80%. However, there had been an increase in patient restraints in the 6 months prior to our inspection on Church and Oak ward. The service told us this was due to high acuity and a small number of specific patients. The service was confident that the reasons for restraint were fully understood and were being closely monitored. Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. We reviewed 8 patient care records following rapid tranquilisation on the Women's wards. We saw that 6 patients had received physical health observations; 2 on Oak ward had not. Post rapid tranquilisation observations were not always consistently recorded in the same place within the patient record. This meant that staff could miss important physical health information.

We reviewed 8 patient care records on the Men's wards and did not see any occasions where rapid tranquilisation had been used, despite patients being prescribed it.

We reviewed 11 seclusion records. When a patient was placed in seclusion, staff generally kept clear records and followed best practice guidelines. Clinical staff received training in seclusion; all wards were above 88% compliant. The use of seclusion had reduced on the Women's wards. Data from Bracken, Willow, and Maple wards from July 2022 to July 2023 showed that no patients had been secluded since December 2022. In between July 2022 to December 2022, seclusion had been used 24 times. We did not receive similar data for the learning disability wards which included both Men's wards, and 2 from the Women's service, Church and Oak.

Of the 7 seclusion records we reviewed on the Men's wards, we found 1 record did not have a medical review within 1 hour of commencemnt, in line with the Mental Health Act code of practice. All other records had regular medical and nursing reviews and observations were clearly documented every 15 minutes.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation (LTS). Patients in LTS received regular reviews and had appropriate periods of supervised community leave. There was one patient on long term segregation nursed in the extra care suite on Sunley ward. We reviewed the LTS plan and could see evidence of best practice.

Safeguarding

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

Requires Improvement

Forensic inpatient or secure wards

Staff received training on how to recognise and report abuse, appropriate for their role. The provider had implemented safeguarding navigators to support staff with safeguarding processes and share good practice. However, some health care assistants told us that they felt their safeguarding training was not totally sufficient for their needs.

Staff were kept up-to-date with their safeguarding training. All clinical staff were required to complete safeguarding children, young people and adults' level 1 and 2. As of the 30 June 2023, the Women's wards were over 90% compliant. Registered nurses were required to complete safeguarding level 3. Lowest compliance was Willow ward at 75%; this equated to 2 out of 8 staff, although they were 88% compliant for the on-line training. For the Men's service, both wards were compliant for level 1 and 2. However, Sunley ward was only 63% and Meadow only 57% compliant for safeguarding level 3. Neither were compliant for their on-line level 3 training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. On the Women's service, Church ward had received significant input by safeguarding leads which included more training and supporting staff; this was due to previous identified concerns. The manager discussed safeguarding and incident reporting in supervision and said that improvements had been made.

Staff followed clear procedures to keep children safe when visiting. Rooms outside of the ward area were available for visitors.

Staff from both services knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding concerns were recorded as incidents on the provider's incident reporting system. Appropriate referrals were made to the local authority and managers took part in serious case reviews. Changes were made based on the outcomes.

Staff access to essential information

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

Patient notes were comprehensive and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records.

The provider used an electronic patient care record so records were stored securely. The electronic patient care record stopped working for a few hours during the night shift when we visited. This was escalated to on call senior managers. Managers said they reverted to paper-based notes and had grab sheets readily available with patient care needs.

Staff from both services, used electronic hand-held devices so they could input patient care data, such as enhanced observations and physical health charts, easily and timely. This was automatically uploaded to the provider's electronic patient care records.

Medicines management

The service did not always follow systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff from both services did not always follow systems and processes to prescribe and administer medicines safely. Staff stored and managed all medicines and prescribing documents safely. Patient allergies were included on the front of the prescription cards. Medication storage facilities were secure, clean and tidy. Medications were kept at the right temperature when opened, these were clearly labelled with a date of opening and use by.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. However, on the Women's service, Church ward did not have easy read patient medication information leaflets readily available.

We reviewed 38 patient prescription cards across both services. Staff generally completed medicines records accurately and kept them up-to-date. However, on the Women's service we reviewed 7 prescription cards on Church ward and found that 4 lawful authority for treatment forms (T2 and T3) were not fully completed or were not up to date. This was rectified immediately.

Staff completed monthly clinic room audits and pharmacy staff carried out audits for medicines management and controlled drugs compliance. On the Men's service, Sunley had a compliance rate of 79% for medicines management and 70% for controlled drugs. Meadow ward had a compliance rate of 86% for medicines management and 70% for controlled drugs. On the Women's service, Church and Bracken ward had achieved over 80% in the medicines management and controlled drugs audit. Willow, Bracken and Maple had achieved between 68% and 79% for both audits, and Bracken 45% for the controlled drugs audit. Action plans were in place for the wards that were not fully compliant and managers could describe progress being made and were aware of any outstanding actions.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services and staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The provider complied with the STOMP (stopping the over medication of people with a learning disability, autism or both) requirements for patients on the learning disabilities wards.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Patients received regular blood tests and ECGs.

Reporting incidents and learning from when things go wrong

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

At our previous inspection, we found that incidents were not always recorded appropriately or accurately in the patient care record. At this inspection, we found that this had improved. Staff knew what incidents to report and how to report them. We reviewed 40 incidents across both services and found that they were consistently and accurately recorded in both the electronic care notes system and the incident data system.

Staff raised concerns and reported incidents and near misses in line with provider policy. On the Women's service, staff had reported 5219 incidents in the 3 months prior to our inspection. Of these, 98% were categorised as no harm or low harm. On the Men's service, there were 349 incidents in total reported for both Sunley (228) and Meadow (121) ward. Managers said there was a positive reporting culture on the wards.

Staff reported serious incidents clearly and in line with the provider policy. For the Women's service, in the 3 months prior to our inspection there was 1 serious incident reported on Church ward and 2 serious incidents reported on Willow ward. All 3 had been referred to the Local Authority and CQC as a safeguarding notification.

Requires Improvement

Forensic inpatient or secure wards

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff were able to give examples of this. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident and staff were supported following all incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents were discussed in daily risk meetings, team meetings and supervision. Actions were included on incidents recorded, and staff were supported to prevent further incidents.

Staff met to discuss the feedback and look at improvements to patient care. Matrons shared a lessons learnt bulletin weekly with staff. Managers and staff regularly reviewed incident data and had made adaptions to help reduce incidents. Learning alerts and key issues from the learning lessons group were sent to all staff. On the Women's service, Willow and Bracken wards held co production meetings with patients about restrictive practices which had resulted in a reduction of incidents, levels of restraint and seclusion. Staff on the wards held reflective practice sessions to discuss patient care and ways in which incidents could be further reduced.

There was evidence that changes had been made as a result of feedback. On one of the Women's wards, Church, there had been a serious incident of a patient swallowing vape juice by breaking open the vape, which posed a serious health risk. Actions included changing the vapes used on the ward to ensure they were more robust. A new protocol was now in place for vaping across the ward, which was included in patients' support plans.

Managers shared learning with their staff about never events that happened elsewhere.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. However, Sunley ward did not have adequate leadership capacity.

Staff we spoke to said ward managers were supportive, approachable, accessible, and visible.

The provider had recently implemented the Thrive programme as part of their new strategy. The initial phase had strengthened leadership for frontline staff by putting general managers and quality matrons in place for each service. The aim was to give extra support to ward managers and staff on the ward, and improve consistency across the service. Staff we spoke with were positive about these changes and felt that the extra support was helpful and beneficial for them.

However, some ward managers were concerned that they would soon be managing 2 wards instead of 1. They felt there had not been enough consultation or a sufficient impact assessment. They felt this would impact on their time to manage staff and effectively oversee the wards.

Requires Improvement

Forensic inpatient or secure wards

On the Women's service, to improve concerns identified on Church ward, senior staff had redeployed an experienced ward manager from another area of the hospital. They worked with the 2 clinical nurse leads proactively so there was a consistent leadership presence.

On the Men's service, at the time of inspection, there had been no ward manager on Sunley ward and only one clinical nurse lead for at least 3 months. This had placed extra responsibilities and tasks on the sole clinical nurse lead. This lack of staff in leadership positions had resulted in a reduction of staff supervision and training compliance. However, staff told us there were managers due to start imminently and the quality matron was on the ward at the time of our inspection.

Culture

Generally, staff felt respected, supported, and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. Generally, they could raise any concerns without fear.

On the Men's service, staff on Sunley ward told us they did not always feel supported or respected from managers and did not always feel information was clearly communicated, specifically around the changes to the leadership of the ward.

The provider had initiated a number of approaches to prevent any occurrence of a closed culture across all wards. Managers ensured there was a consistent leadership presence and included staff from all shifts in information sharing and were available for support when needed. Staff attended regular team meetings, reflective practice sessions and received regular supervision. Supervision levels had improved although Oak ward from the Women's service was low at 54% at June 2023. Managers said this was due to a high acuity level although senior staff were addressing this. Patients attended ward community meetings, and patient's complaints could also be forwarded to the patient advice and liaison service for transparency. The independent advocacy service and the social work team supported patients when needed and staff reported any concerns through the safeguarding process and the Local Authority. Patient representatives were able to express any concerns patients had to a wider forum meeting.

Ward managers from both services gave examples of when they had dealt with issues with poor behaviour, boundary issues or poor language being used. Managers had acted quickly and appropriately. On the Women's service, concerns about culture had been identified on Church and Oak ward. Some staff had not displayed the provider's values and appropriate actions had been taken. New staff had been recruited which had had a positive effect.

Managers we spoke with from both services were confident that culture had improved on the wards. They completed self-culture assessments in line with the provider's values and invited external visitors such as senior staff, quality teams and governors to visit. The provider had implemented the 9C's Culture Change programme as an improvement plan for the Women's service following our previous inspection. The emphasis was on changing the culture by focussing on high quality care, in conjunction with the new ward governance framework.

Staff felt able to raise any concerns they had to their line managers. The provider also had a Freedom to Speak up Guardian in post to support staff if they wanted to raise a concern.

All staff had the opportunity to raise concerns to senior staff through the 'safe call' system without fear of reprisal. In the six months prior to our inspection, there were 3 safe calls from the Women's service. Willow ward had received one relating to disparity of treatment and contraband on the ward. This was partially upheld. There were 2 for Bracken

relating to staffing levels and the use of agency staff. This was still being investigated. On the Men's wards, there were 11 safe calls from Sunley ward, with 9 relating to staffing levels, 1 regarding the shift pattern change and 1 relating to working relationships. There had been 1 safe call on Meadow ward for the same period relating to staff sleeping whilst on duty.

The provider carried out a Your Voice Snapshot Survey in 2023. This comprised of 6 questions that fell under 3 categories: energy, pride and optimism. The learning disability and autism division which included both Men's wards and Church and Oak wards from the Women's service had a score of 75% for energy, 57% for pride and 58% for optimism.

The provider's staff results (2023) showed that staff felt more engaged and optimistic about their work than previous years. Staff were encouraged to nominate each other for the provider's award nominations.

Staff on Willow ward from the Women's service said they had seen improvements on the ward and there was a 'great' culture'.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk was not managed well.

At our previous inspection, we asked the provider to undertake audits on patient observations and that incidents were recorded appropriately, and those findings were reported to CQC every fortnight. We found that staff compliance with the provider's engagement and observation policy had improved. We found that staff were recording incidents appropriately and accurately within the patient care record and the provider's incident reporting system. However, during our visit, we found that there was data missing from the e-observations with some observations missing or late.

Managers from both services had access to performance dashboards which gave them an overview of the ward performance including staffing, mandatory training and supervision compliance. However, there was a lack of good quality oversight in managing performance as highlighted by low compliance rates for training and supervision from some of the wards. Governance processes were not working effectively to pick up on areas that needed improving.

The provider had implemented a detailed dashboard for patient observations which meant managers could review and manage late or missed observations quickly.

There were a number of meetings in place at all management levels and these fed into the board. Each ward had a monthly clinical governance meeting that fed into the directorate clinical governance meeting. Other meetings included huddles, incident reviews and community meetings. We saw minutes of these meetings which had a standard agenda and clear actions assigned to the relevant people.

Church ward from the Women's service had been identified as a 'ward of concern'. This meant that the provider had recognised areas where improvement was required through governance processes and extra resources and support had been made available. The ward had concentrated primarily on leadership, staffing, activities, and culture. Improvements had been made; however, the ward had not yet provided sufficient therapeutic activities and the environment required attention.

Requires Improvement

Forensic inpatient or secure wards

The provider's quality strategy set out how the governance processes in place at ward level would ensure that the provider would deliver high quality care to their patients.

Management of risk, issues and performance

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

Wards had individual risk registers in place and these matched the concerns of the staff. Managers were able to add items onto the risk register as necessary and these risks were reviewed regularly at clinical governance meetings.

Managers collected a range of care delivery information, such as key performance indicators. The provider had access to a wide range of performance data such as training, supervision, and appraisals. However, action was not always taken to improve performance data and increase compliance levels for training and supervision.

Information management

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

Managers collected and reviewed ward performance data. This ensured that governance processes and procedures were effective and helped staff quickly identify wards of concern, but also areas of good practice. Due to the lack of ward manager and one clinical nurse lead on Sunley ward, this was reviewed by the remaining clinical nurse lead with support from the quality matron. Through the division quality surveillance group, a number of outcomes such as the Clinical Global Impression Scale (CGI), the Autism Spectrum Star and the Maslow Assessment of Needs Scale – Learning Disability (MANS-LD) were used. The service also engaged in a number of quality improvement activities based on national quality improvement methodologies, for example The Quality Network for Forensic Mental Health Services (QNFMHS).

Learning, continuous improvement and innovation

The provider carried out regular quality reviews in numerous areas such as E-observations. Where any areas of improvement were identified, the service sent out a learning alert to share any learning identified. Additionally, the learning lessons group sent out regular information around incidents that are discussed, any learning identified and key messages to be shared.

The provider had made Eye Movement Desensitisation and Reprocessing (EMDR) therapy available to patients where previous therapies have not worked. The service had also implemented Meriden Behavioural Family Therapy (BFT) programme and hope to work with more families.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider must ensure that patients have access to easy read information when required so they can fully understand their care and treatment. (Regulation 9 (3)(g))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider must ensure that physical observations are consistently recorded within the patient care record. (Regulation 12 (2)(b)) • The provider must ensure that e-observations are entered in real time to ensure patient safety. (Regulation 12(2)a)) • The provider must ensure staff effectively plan shifts so they do not carry out enhanced observations one after the other. (Regulation 12(2)b)) • The provider must ensure that staff are aware of systems in place to check emergency equipment and other clinic room equipment is checked and audited to ensure it is not out of date. (Regulation 12(2)(e)) • The provider must ensure that medicines management processes are fully adhered to in line with the provider's policies and procedures. (Regulation 12 (2)(g))

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

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider must ensure that staff are fully compliant with their training needs, including safeguarding training. (Regulation 18(2)(a)) • The provider must ensure there are robust processes in place to ensure that staff receive regular clinical supervision. (Regulation 18(2)a)) • The provider must ensure that all wards have sufficient qualified nurses to meet their establishment on night shifts. (Regulation 18 (1))
	• The provider must ensure that they have robust governance processes in place to ensure the monitoring and oversight of training, supervision, observations and equipment and have a robust audit programme in place to address any compliance issues. (Regulation 17(1))