

West London Mental Health NHS Trust

Forensic inpatient/secure wards

Quality Report

The Orchard
St Bernard's Hospital
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RKL53	St Bernard's and Ealing Community Services	Aurora ward Damson ward Garnet ward Parkland ward Pearl ward Melrose ward	UB1 3EU

This report describes our judgement of the quality of care provided within this core service by West London Mental Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by West London Mental Health NHS Trust and these are brought together to inform our overall judgement of West London Mental Health NHS Trust.

Summary of findings

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

We did not rate this service.

We found some areas which the provider needs to improve

- At our last inspection in June 2015, we found that staffing levels were not sufficient to guarantee the safety of patients and staff and that the lack of staff had a significant impact on the quality of life of patients. During this inspection we found that while there was demonstrable evidence of an effort to increase recruitment to nursing posts within the service, there were still vacancies, particularly on Parkland and Melrose wards which were the enhanced medium secure services. This meant that some nurses were moved between wards and patients told us that escorted leave as well as therapeutic and leisure activities were sometimes cancelled. This had impacted the quality of care across the service. This was an area where further improvements were needed.
- At our last inspection in June 2015, we found that restraint and seclusion were not appropriately recognised and were not only used when needed and recorded so that the use could be reviewed. At this inspection we found that while the staff in the service were recognising the use of restraint and seclusion appropriately and only using it when needed, the recording still needed to improve. There continued to be significant gaps in the paper records relating to seclusion on a number of wards. For example, some records had gaps where staff had not completed records of continuous observation every thirty minutes and some records did not include regular nursing or medical reviews. This meant that we could not be provided with assurance that the correct observation and monitoring had taken place when patients were subject to seclusion. This was an area where further improvements were needed.
- Incidents of restraint were recorded comprehensively on incident reporting forms. However, staff on the wards, including ward managers, did not have access to information about the type and length of time that restraint was carried out in the electronic records.
- Some seclusion rooms, particularly on Melrose and Garnet wards, were on occasion registering

temperatures above 25°C. This meant there was a risk that temperatures were not maintained at a comfortable level. The service was mitigating this by trying to use other seclusion rooms where possible and managers within the service were aware of this.

- While incidents were recorded, all information about incidents was not available to ward managers if they had been signed off by another member of staff. This meant that there was a risk that ward managers would not have an oversight immediately of the detail of all incidents on their wards.
- Some staff on Parkland ward told us they had not had regular supervision in the year prior to the inspection; however, this had improved recently. This had not been identified as a concern at the previous inspection in June 2015.

However, we also found some good practice.

- We saw that the service had made significant improvements since the last inspection in June 2015 and that they were focussed on continuing to improve.
- At our last inspection in June 2015, we found that staff engagement and morale was poor and that staff identified that they did not feel comfortable raising concerns within the service to their managers and to senior managers in the trust. During this inspection, we saw that work on staff engagement had been positive and most staff reported that they felt supported by their managers at a ward, service and trust level. There had been a significant improvement in this area.
- At our last inspection in June 2015, we found that the trust had been using blanket restrictions inappropriately on wards and that these did not reflect individual patient needs. During this inspection we saw that there had been a focus on reducing restrictive practice and blanket restrictions across the service. This had had a positive impact on the care and treatment of patients and the culture within the service by ensuring that care was more person-centred. This was an improvement since the last inspection.
- At our last inspection in June 2015, we found that patients did not consistently have records of physical health checks. During this inspection we found that

Summary of findings

patients had access to physical health care from primary health care services which were provided on site, regular physical health checks by nursing and medical staff on the wards and access to acute general hospital when necessary and that these were recorded to demonstrate that they were taking place. This was an improvement since the last inspection.

- At our last inspection in June 2015, we found that audits were not consistently completed on the wards and that information from audits was not always used to drive improvement. During this inspection we found that there were robust governance arrangements in place including the use of clinical improvement groups throughout the service to ensure that information about incidents, complaints and audits was disseminated through to ward staff as well as up to the service and trust management teams. There had been improvements in the governance processes and how this impacted on practice on the wards since the last inspection in June 2015.

- Patients in the service had access to multi-disciplinary support including occupational therapy, psychology and social work as well as nursing and medical support.
- Staff had introduced the 'safe wards' programme into the unit which included person-centred work aimed at reducing violence and aggression on the wards. For example, by focussing on the use of language through the soft words project which focussed on the impact of language on care.
- Most patients reported that staff were kind and caring. This reflected our observations on the wards when we visited.
- Patients had access to a wide range of therapeutic and leisure activities, including work-focussed activity such as work in the on-site café, library and shop.

Summary of findings

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

Are services safe?

We did not rate this service.

We found some areas in which the provider needs to improve

- Seclusion rooms on some of the wards, particularly Garnet ward and Melrose ward had recorded high temperatures over 25°C for a number of days through the summer. This meant that there was a risk that patients were not being provided with optimum care. The service was aware of this issue and took steps to mitigate where possible, for example, by using other seclusion rooms within the service.
- During our last inspection to the service in June 2015, we found that staff were not always recognising seclusion and appropriately recording it. We saw that there had been some improvements so that staff recognised and identified seclusion but there were continuing gaps in the records which related to seclusion. At this inspection, we found gaps in the paper seclusion records, including records of continuous observation which was recorded on every thirty minutes and records of nursing and medical reviews. There was some inconsistency between paper records and electronic records of seclusion. This meant that we could not be assured on the basis of records available that all required observation and monitoring was taking place. However, a new pilot was taking place on Melrose ward to look at streamlining the reporting process.
- Incidents of restraint were recorded on incident forms. However, detailed information about the type and length of restraint were not recorded in patients' electronic records.
- During our last inspection to the service in June 2015, we found that there were staff vacancies which means that staffing was not consistently provided at safe levels and that this had an impact on the quality of life of patients due to restricting access to therapeutic services and escorted leave. At this inspection, we found that there were twelve vacancies for nurses at the time of our inspection with most vacancies on Parkland and Melrose wards. Staff and patients told us that sometimes escorted leave was cancelled and the lack of regular staff meant that there was an impact on the quality of care regarding access to therapeutic and leisure activities.
- Ward managers told us they were not able to review all information about incidents including incidents of restraint on their wards in detail if they had been signed off by other members of the ward or service team.

However we also found areas of good practice

Summary of findings

- During our last inspection in June 2015, we found that staff used restrictive practices such as blanket restrictions on the wards where they were not always necessary. During this inspection, we found an improvement in this area. Staff focussed on minimising restrictive practices and reducing blanket restrictions as far as possible. We saw that significant work had been focussed on the reduction of blanket restrictions since our last inspection in June 2015.
- During our last inspection in June 2015, we found that some patients that were being prescribed medication at higher than the recommended maximum dose, were not having appropriate reviews and checks according to national guidance. During this inspection, we found that where this practice took place, reviews were regular and documented. This was an improvement since the last inspection.
- Staff had a good understanding of seclusion and recognising it to ensure that appropriate safeguards were in place.
- Staff were aware of the trust incident reporting process and gave us examples of learning from incidents which had taken place across the service.
- All areas we visited within the service including clinical and non-clinical areas were clean and well-presented.
- All wards had well-equipped clinic rooms with equipment to monitor physical health and to manage medical emergencies.

Are services effective?

We did not rate this service

We found the following areas of good practice:

- During the previous inspection in June 2015, we found that there were gaps in the Mental Health Act documentation which we checked. During this inspection we found that the on-site Mental Health Act office carried out regular audits of Mental Health Act documentation and that this was up to date. This was an improvement since the last inspection. .
- During the previous inspection in June 2015, we found that records related to physical health checks were not consistently completed. During this inspection we found that all patients had physical health checks regularly. These were recorded. This was an improvement since the last inspection.
- Care plans were generally comprehensive and holistic, reflecting the wants, needs and preferences of patients and incorporating their views clearly.
- Staff had a good understanding of the Mental Capacity Act and the way it was used on the wards.

Summary of findings

- There were multi-disciplinary teams on all wards which included psychologists, social workers and occupational therapists working together as well as medical and nursing staff.
- Staff on the wards accessed regular team meetings including clinical improvement groups.
- Most staff told us they had access to regular clinical supervision and there was a drop in reflective practice group on site.

However, we also found areas in which the provider needs to improve:

- Some staff on Parkland ward told us that they had not had consistent access to clinical supervision over the year prior to the inspection.

Are services caring?

We did not rate this service

We found the following areas of good practice:

- Most patients we spoke with were positive about the staff and the care which they received.
- We observed care being delivered in a kind and empathetic manner, including observations of direct care and also in relation to the language that staff used to describe patients and their needs.
- Staff on wards had a good understanding of the individual needs of specific patients as well as their preferences.
- There were strong networks of patient involvement through the service, including a well-established patient forum, community meetings on each ward and a magazine developed across the forensic services. Patients at The Orchard had contributed to the magazine and were proud of their contributions.
- Patients told us they were involved in their own care planning and were aware of their care plans.

Are services responsive to people's needs?

We did not rate this service.

We found the following areas of good practice:

- During our last inspection in June 2015, some patients had reported to use that they did not feel able to make complaints or feel comfortable doing so. During this inspection, we saw

Summary of findings

that information was available about how to complain within the service. Patients we spoke with told us that they knew how to make complaints. This was an improvement since the last inspection.

- There were few delayed discharges and there was a clear referral pathway into the service.
- The hospital was purpose built in 2007 and had ensuite bedrooms as well as space for therapy groups, activities, and meeting areas. There were separate visitors' areas for adults and children who visited and these were off the ward areas.
- There was an extensive range of activities based in The Atrium which was a central area for patients to use. These included work-based activities such as a shop, café and library as well as a gym area. There was a drop-in service from the advocate and access to a primary health care suite.
- Patients had access to a chaplain and additional support could be provided regarding specific religious needs.
- Staff had access to interpreters and were proactive in booking them.

However, we also found areas in which the provider needs to improve:

- Some patients and staff told us that sometimes activities were not provided regularly, particularly on wards, such as Parkland ward where patients may be less likely to have leave to access the Atrium.

Are services well-led?

We did not rate this service

We found the following areas of good practice:

- During our previous inspection in June 2015, staff reported to us that they felt morale in the service was poor and we received some specific concerns related to bullying. During this inspection, we found that the staff we spoke with were generally happy, positive and felt confident raising concerns internally. There had been significant work to improve staff engagement since the last inspection in June 2015 which was evident in positive feedback from staff and this was an improvement. .
- There was a staff forum which took place monthly and was open to all staff to attend.
- There was also a bulletin distributed through the service on a monthly basis to all staff which included updates from the staff forum, patient's forum, specific feedback and learning from incidents within the service. This helped to ensure that all staff

Summary of findings

had an understanding about how the service was performing and had up to date information about key issues and opportunities – for example, training and secondment opportunities.

- Information was provided through the service from the ward manager to the service manager and up to the trust and back through meetings which took place across the service. However, some ward managers reported that they did not have access to all information at a ward level, for example, feedback from all incidents.

Summary of findings

Information about the service

We inspected The Orchard which is the women's forensic service at West London Mental Health Trust and is part of the West London Forensic Service. All the wards at The Orchard are based on the same site at St Bernard's Hospital. The service comprises of 60 beds in total which includes the women's enhanced medium secure service (WEMSS), medium secure services and low secure services.

There are six wards:-

Pearl ward - 15 beds, female low secure.

Aurora ward – 10 bed, female medium secure admissions

Garnet ward – 10 bed, female medium secure rehabilitation

Damson ward – 5 bed, female medium secure rehabilitation

Parkland ward – 10 bed, female enhanced medium secure treatment

Melrose ward – 10 bed, female enhanced medium secure treatment.

This service was last inspected in June 2015 where it was part of the comprehensive inspection of forensic inpatient/secure wards which included Tony Hillis wing and Three Bridges as well as Broadmoor Hospital.

Our inspection team

The team which inspected this service included four CQC inspectors, one CQC inspection manager, one Mental Health Act Reviewer, two specialist advisors who had

experience of working in forensic mental health services and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses similar mental health services.

Why we carried out this inspection

We undertook this inspection to find out whether West London Mental Health NHS Trust had made improvements to their forensic inpatient/secure wards since our last comprehensive inspection of the trust on 8th – 11th June 2015.

When we last inspected the trust in June 2015, we rated forensic inpatient/secure wards as inadequate overall. We rated the core service as inadequate for Safe, good for Effective, good for Caring, good for Responsive and inadequate for Well-Led.

Following this inspection, we told the trust it must make the following actions to improve forensic/secure services:

Broadmoor Hospital

- The trust must ensure that staffing levels are sufficient to promote the quality of life of patients in terms of ensuring they can access therapeutic and leisure activities as agreed in their care plan.

- The trust must ensure that staff are engaged in the running of the hospital and that communication with staff at all levels and in all areas of the hospital improves. This is to ensure that better care can be provided to patients and that staff feel that the environment and culture of the hospital and trust is one that values their input and engagement.

West London Forensic Services

- The trust must ensure that staffing levels are maintained to guarantee the safety of patients and staff and that the lack of staff does not have a significant impact on the quality of life of patients in the service in terms of access to therapeutic activities, escorted leave and meetings with named nurses. Staff must not work excessively long hours.

Summary of findings

- The trust must ensure that all seclusion facilities are in a state of adequate repair and consideration is given to the maintenance of the patients' dignity when using the facility.
- The trust must ensure that restraint and seclusion is appropriately recognised; only used when needed and recorded so its use can be reviewed.
- The trust must review blanket practices across the wards to ensure these only take place where needed and that as far as possible practices reflect individual patient need.
- The trust must ensure that where patients are prescribed medication above the recommended dose the national guidance must be followed.
- The trust must ensure that more targeted work takes place to address the complex issues affecting staff engagement so that communication between

management within the service and members of staff is facilitated. This is to improve morale and ensure that staff feel comfortable raising concerns with their managers and the senior managers in the organisation.

We issued the trust with five requirement notices that affected forensic inpatient/secure wards

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 18 Staffing

Regulation 13 Safeguarding service users from abuse and improper treatment

Regulation 17 Good governance

Regulation 9 Person-centred care

Regulation 12 Safe care and treatment

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We looked at information provided to us on site and requested additional information following the inspection visit relating to the service.

During the inspection visit, the inspection team:

- Visited all six of the wards at The Orchard, looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 34 patients who were using the service.

- Spoke with the managers or acting managers for each of the wards.
- Spoke with 37 other staff members; including doctors, nurses and social workers.
- Interviewed the clinical lead and senior nurse for the service.
- Attended and observed two hand-over meetings and three multi-disciplinary meetings and one nursing handover.

We also:

- Looked at 18 treatment records of patients.
- Checked 29 seclusion and observation records.
- Looked at a sample of five incident reports related specifically to restraint.
- Looked at 20 prescription charts.

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

What people who use the provider's services say

We spoke to 38 patients over the course of the inspection. Most feedback we received was positive about the staff attitude, responsiveness and empathy. Some people raised concerns about their care. For example, some

patients told us that they had escorted leave cancelled or raised concerns about staffing levels and staff being moved around the hospital to different wards when they preferred to have regular staff on site.

Summary of findings

Good practice

- The Atrium, which is the central communal area, ensured patients had access to different occupational and therapeutic activities centrally.
- The service had worked extensively on minimising restrictive practices in the unit and this was evident and had made a positive impact on care provided in the unit.
- The implementation of the 'Safe wards' programme across the service was having a beneficial impact on the experiences of staff and patients across the service.
- The development of 'The Grove' a monthly staff newsletter which included information about the service, updated from the patient and staff forums as well as recent learning from incidents and near misses, training opportunities and positive news across the service.
- The service had progressed significantly in terms of staff morale through the development of the staff forum and availability and visibility of the senior management within the unit.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that staffing is provided at a level which enables the quality of care to be provided to patients including access to therapeutic and leisure activities including planned escorted leave. This is a continued requirement from the previous inspection in June 2015.
- The trust must ensure that recording of seclusion is clear and accurate and reflects actions taken by staff to ensure the safety and wellbeing of patients who are subject to restrictions. This is a continued requirement from the previous inspection in June 2015.

Action the provider **SHOULD** take to improve

- The trust should continue to work to ensure that incident reports are accessible to ward managers so that immediate information following incidents can be provided locally.

- The trust should ensure that when an incident of restraint takes place on a ward, that information about the type of restraint used and the length of time that it was for is accessible to members of staff providing care to that patient.
- The trust should ensure that the temperature in seclusion rooms is able to be controlled externally and where it is uncomfortable for patients, it is adjusted appropriately.
- The trust should continue to ensure that all clinical staff have access to regular individual supervision and that this is monitored regularly at a ward level.
- The trust should consider monitoring patients' cancelled leave and activities to determine the impact of staff shortages on individual patients care and treatment.

West London Mental Health NHS Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
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Aurora ward
Damson ward
Garnet ward
Parkland ward
Pearl ward
Melrose ward

St Bernard's and Ealing Community Services

Mental Health Act responsibilities

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

During this inspection, the team was accompanied by a Mental Health Act reviewer who carried out one Mental Health Act review visit to Aurora ward.

We found that there was a good understanding across the service of the Mental Health Act and that staff on the wards were supported by a Mental Health Act office which was based on site at St Bernard's Hospital.

We checked eight records held centrally at the Mental Health Act office and two records on Aurora ward. We found that Mental Health Act documentation was securely held and that there was a record of staff ensuring that patients' were given information about their rights on a regular basis.

The Mental Health Act office conducted regular audits of Mental Health Act paperwork at The Orchard to ensure that this was present and correctly completed and recorded.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff we spoke with had a good understanding of the Mental Capacity Act. The trust had recently changed the training around this so that it was mandatory. Where staff had not yet received this training, they were booked to complete it in the months subsequent to the inspection.

While staff were able to describe to us good examples of practical use of the Mental Capacity Act and we saw care

records which details how decisions had been made reflecting use of the Mental Capacity Act, there was not a consistent way that this was recorded. This meant there was a risk that information might not be obviously available for staff looking at patient records.

Are services safe?

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

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

Our findings

Safe and clean environment

- The Orchard is a purpose built hospital. There were good sightlines within communal and corridor areas on the wards. All wards had ligature and environmental risk assessments which identified the areas of the wards where patients were at higher risk. Staff used this information to manage risk by ensuring, for example, that patients were supervised in higher risk areas where there was an identifiable risk.
- The service had an annual ligature risk assessment which had been completed and was up to date. Staff on the ward carried out a monthly ligature risk audit which ensured that the assessment was up to date. Wards had ligature risk maps which rated areas according to traffic light colours with red being a high risk area, yellow being medium risk and green being low risk. This visual aid ensured that staff had a quick and easy reference to areas which needed additional observation levels. The risk of ligature anchor points was mitigated by staff understanding of patient need and risk level and by observation when necessary.
- All ward areas we visited were visibly clean. Patients and staff reported that they did not have any concern about the levels of cleanliness on a day to day basis.
- Infection control audits were carried out regularly. As well as an annual audit, ward staff carried out monthly audits. All wards had alcohol hand gel dispensers available at the entrance to the ward. Clinic rooms had sinks.
- Some wards had seclusion rooms. Pearl ward had two seclusion rooms. We were not able to check all the seclusion rooms on site as some were in use during our inspection visit. However, they had ensuite toilets, two way radio communication and good visibility for staff. Clocks were visible. However, some seclusion rooms registered temperatures which were higher than 24°C which is the temperature recommended by the Trade Union Congress above which employers should attempt to reduce the temperature. For example, between 1 July 2016 and 31 July 2016 the seclusion room on Melrose ward registered above 25°C on 12 days and on Garnet within the same time period there were 9 days when it

registered over 25°C. On one occasion, on Garnet ward the temperature reached over 30°C in the seclusion room. The patient was offered a move to a seclusion room on a different ward at this point but chose not to move. The service were aware of the difficulties in regulating the temperature in seclusion rooms and where possible offered patients the opportunity to move to seclusion rooms which did not have temperatures which registered as highly. However, due to the nature of the use of the rooms, this was not always possible.

- All wards had access to clinic rooms which had emergency equipment available, for example, defibrillators. These were checked weekly. Staff on the wards had undertaken training in basic life support and were aware of the locations of ligature cutters on the wards.
- All staff had access to a personal alarm which were distributed at the entrance to the unit. These were regularly checked and serviced.

Safe staffing

- At our previous inspection in June 2015, we identified that the level of qualified nurses at the time did not ensure that staffing provided at a sufficient level to meet the needs of patients in the service. At this inspection we found that while there had been some improvements and additional work had been done on tailored recruitment, this was a continuing concern. At the time of our inspection, there were twelve nurse vacancies at The Orchard. There were six vacancies on Parkland ward, five vacancies on Melrose ward and one on Damson ward. Nine patients across all the wards told us they had concerns about staffing levels. Eleven members of staff also raised concerns with us about staffing numbers. Two members of staff told us the situation had improved over the year prior to the inspection. Some patients and staff specifically told us that leave had been cancelled. For example, one patient on Parkland ward told us they had leave to go to the Atrium but had not been able to use this for over a week due to the staffing levels on the ward as there were a number of people who required additional support. Another patient told us that they had been given escorted leave to attend church on the Sunday prior to

Are services safe?

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our inspection but this had been delayed due to a shortage of staff and she had missed the church service as a result, although she had been offered postponed leave. The service did not log how frequently leave was cancelled due to a lack of staffing.

- Some staff and patients told us that staff were moved between wards during shifts to ensure that staffing levels are safe across the hospital site. However, this meant that sometimes patients were not being provided with care by the nursing staff who knew them best.
- We checked the rotas for the service and the gaps between staff required and staff available. For example, on Pearl ward in June 2016, 30 shifts out of 90 had been short by one nurse. 24 of these were night shifts and 23 were covered by additional HCAs. In July 2016 on Pearl ward, 8 shifts out of 93 were short by one nurse. Three morning shifts had three members of staff on duty when there should have been five. On some days when wards were short of staff, the unit coordinator indicated that they would cover the shift. However, on some days, more than one ward stated that the unit coordinator was covering their shift. This meant that there was a continuing impact of staff numbers being low on the wards.
- Since the last inspection in June 2015, the trust had focussed on recruiting nursing staff. This included running open days which were specifically targeted at nurses who were interested in working in forensic services for women. The open days including presentations from staff and patients as well as interviews on the same day. These had paused over the summer period but were re-starting in the autumn. One student nurse we spoke with was very positive about their experience and support through their placement and a newly qualified nurse told us that they were satisfied with the support they received through their preceptorship programme. New substantive ward managers had been appointed for Parkland and Melrose wards. Staff on those wards were very positive about the input from their ward managers.

Assessing and managing risk to patients and staff

- In the period between 1 January 2016 and 30 June 2016, there had been no use of restraint on Garnet, Damson or Pearl wards. The highest number of incidents of restraint was on Parkland ward where there had been 31 incidents reported involving five different patients. Of these, 14 were restraints in the prone position. The

second highest number of incidents of restraint being recorded was on Melrose ward where there were 21 incidents of restraint involving five different service users, of which nine were in the prone position. On Aurora ward, in this period, there were three incidents of restraint.

- In terms of seclusion, between 1 January 2016 and 30 June 2016, there were 66 incidents of seclusion recorded on Melrose ward, 21 on Parkland ward and one on Pearl ward.
- At our previous inspection in June 2015, we saw that sometimes seclusion had taken place when it was not clear in the patient records that it was a last resort intervention. During this inspection was found that staff had a good understanding of relational security and worked to minimise restrictive interventions such as the use of restraint and/or seclusion. Staff we spoke with demonstrated that they saw restrictive interventions as a last resort. This was an improvement since the last inspection.
- At our previous inspection in June 2015, we found that there were some blanket restrictions which were not appropriate for all patients within the service. For example, on Parkland ward, patients had been required to wear seclusion gowns during episodes of seclusion. This was no longer the case. We saw that the trust had focussed on reducing restrictive practices including blanket restrictions and restrictive interventions since our last inspection. Staff spoke with us about restrictive practice conference and reflective practice groups and sessions which had focussed on minimising restrictive practice. Staff were also able to give us examples of moving towards individual risk planning being favoured over blanket restrictions. This was an improvement since the last inspection.
- At our previous inspection in June 2015, we found gaps in seclusion records where nursing and medical reviews were not records and where there were some gaps in observation records through the course of an episode of seclusion. We found that this was a continued concern. We checked seclusion records on the wards we visited. We found significant gaps in the records on Garnet and Parkland ward with some gaps evident on other wards we visited. For example, on Parkland ward, some paper records of seclusion could not be located immediately on our arrival. The paper records of seclusion were held in a separate seclusion log which we were told was updated monthly but had not been updated for the

Are services safe?

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month prior to our visit. We also looked at a sample of eight seclusion records which were held on paper. There were gaps identified on all of them. These gaps included areas where observations were not recorded and also gaps on their front sheets which indicated why the seclusion had been initiated and when it had ended. For some of these records, we checked the electronic database system and a ward log of 24 hours and issues which arose. We saw that checks had taken place on the patients but they had not been recorded on the paper records. This remained a concern at this inspection.

- On Garnet ward, we also saw that there were gaps in the paper seclusion records which were not reflected in the 24 hour log or the electronic database system. For example, there were gaps in the observation being recorded and on one record we saw that the reason for the seclusion was not clearly documented. Recording of seclusion which was identified during the inspection in June 2015 continued to be a concern.
- Staff showed us how the recorded seclusions on paper records as well as recording medical and nursing reviews on the electronic database and in the ward 24 hour log. Some of this information allowed us to confirm that relevant checks had been completed. However, despite these recording systems, there were still some gaps. Staff on Melrose ward had started a pilot project to record seclusion directly onto the trust electronic database. This was still at an early stage. We saw some records on Garnet ward where there were gaps in recording observations and where reasons for the seclusion were not clearly recorded. This meant that we could not be assured that all the necessary monitoring of seclusion was taking place due to the gaps in the records.
- At our previous inspection in June 2015, we found that some staff were not able to identify episodes of seclusion. Significant work had been done by the management team since the last inspection on clarifying the policy regarding seclusion and staff understanding of it in practice on the wards. Staff had a good understanding of what seclusion entailed, despite there being a number of different terms which were used to describe it, for example, open seclusion and environmental restrictions. In the previous inspection we noted that there was a risk that de facto seclusion may take place where staff did not recognise seclusion. This was no longer the case and we were satisfied that staff understood seclusion and the ensuing protections.
- In the previous inspection in June 2015, we found that some staff had not recognised or recorded all episodes of restraint. During this inspection we found that staff had a good understanding of the need for restraint. This was an improvement since the last inspection. However, we found that while restraint was recorded in incident reports which contained details of the type of restraint and members of staff involved, this was not reflected in the electronic case notes on a day to day basis. There was a lack of consistency in the way that restraint was recorded on the daily records. Ward staff told us that clinical teams were not able to easily access information about specific restraint use as the key record was on an incident report which was then sent centrally without access being retained at ward level. This meant that there was a risk that local discussion about specific restraint incidents may be delayed while information is requested centrally.
- We spoke with patients who had experienced restraint and seclusion. Two people told us that interventions, when they had been carried out had been carried out with staff ensuring that their dignity was maintained.
- Staff had a good understanding of recognising and reporting safeguarding concerns. The wards had dedicated social workers who were employed by the local authority and seconded to the trust so that safeguarding concerns identified on the ward were shared with local authority staff. The wards had a strong reporting culture and the ward social workers attended ward rounds and were a part of the multi-disciplinary team, so were able to feed back on the outcomes of any safeguarding investigations.
- Medicines were stored securely in the relevant clinic rooms. Staff had access to trust pharmacists who were able to provide support for clinicians and advice and information to patients. We checked 20 medication records and found they were up to date and completed without error. At the previous inspection in June 2015, we had raised concerns about policies and procedures when patients were prescribed high dose anti-psychotic medication. We saw that a new policy had been implemented and that where this happened, it was recorded clearly that dosages were above the BNF limit and additional physical health checks were carried out as required. This was an improvement since the last inspection.

Are services safe?

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

- At the last inspection we found some examples of where rapid tranquillisation had occurred, the documentation which evidenced appropriate reviews was not completed. That was not the case in this inspection. This was an improvement.

Track record on safety

- Between 1 April 2015 and 31 July 2016, the service logged seven serious incidents which required investigation as defined by the NHS Commission Board Serious Incident Framework 2015. Six of these incidents were on Parkland ward and one was on Melrose ward. Four of these incidents related to patients causing injuries to themselves and three incidents related to patients threatening or assaulting members of staff.
- Staff and patients told us about recent incidents in the service where there had been areas of learning.

Reporting incidents and learning from when things go wrong

- Staff throughout the service had a good understanding of the process to report incidents and were aware of the importance of reporting incidents and how it fed into the improvement of the service.

- There was an awareness of the duty of candour through the wards and the service management. We were told that where there had been mistakes, the service was open in acknowledging and responding to them.
- Staff told us when they reported incidents through the trust incident reporting system, they received feedback through the ward and service clinical improvement group meetings. These meetings were held monthly and reviewed key ward level information including incidents. However, some ward staff told us that they did not receive feedback about what they described as 'low level' incidents. For example, some ward managers told us that when an incident was reported and it was countersigned, only the person who countersigned it could review the incident in detail at a later date. This meant that the ward manager did not have instant access to all incidents on the ward.
- Staff had a good awareness of incidents not only on their wards but across the service and were able to give us examples of learning which had taken place following incidents. For example, on one ward, a patient who had died in 2015 following the use of a ligature from their clothes. As a result of this incident, staff recorded clothes which patients had been given to ensure that they are clearly sighted to potential risks.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- At the previous inspection in June 2015 we found that while most care plans were comprehensive, some care plans did not have an evident recovery focus. We reviewed 17 care plans across the service. We found that most care plans were comprehensive and holistic with evidence of a focus on recovery and discharge planning. They were individualised and reflected the views of patients within them. This was an improvement since the last inspection.
- Care plans we saw contained specific crisis plans which were completed and indicated triggers for potential deterioration.
- At the previous inspection in June 2015, we found that monitoring of physical health checks had not been consistently completed. During this inspection we found that care planning documentation included physical health monitoring. As well as a physical health check on admission to the service, all patients had key physical health indicators checked regularly, for example, blood pressure, temperature and respiratory assessments at least once a week and more if necessary. The service used the national early warning score (NEWS) which is a specific measure of physical health checks which trigger a medical response when the parameters are outside the normal range. We saw records which confirmed these checks were carried out regularly. This was an improvement since the last inspection. The service had a physical health nurse who was able to provide advice and support where additional focus was needed on physical health.
- Records were kept both electronically and in paper form. Two members of staff told us that they found the electronic records system helpful. Information was secured by smart cards which meant that any changes in the clinical records could be logged centrally. Paper records were also kept on the wards securely in nursing offices. These paper records included letters and documents which related to specific patients.

Best practice in treatment and care

- Each ward had access to a psychologist. Psychologists worked across the service and provided input on a one

to one and group basis. For example, patients had access to cognitive behavioural therapy groups and dialectic behavioural therapy groups as well as one to one sessions with psychologists.

- Patients had access to a GP and primary health suite on site in the Atrium. The service shared a site with an acute general hospital and where necessary, patients were able to access care at the hospital on site.
- A number of audits took place on the ward, both clinical and non-clinical. Nurses on the ward undertook a monthly audit of care plans and risk assessments, ensuring that they were up to date.
- The service used health of the nation outcome scales for secure settings to record and measure outcomes on the electronic database systems. Discipline specific outcome measures were also used. For example, occupational therapists used the standard model of human occupation screening tool while psychologists used individual recovery based goals to measure progress of individuals.
- The service had adopted the "safe wards" model. Safe wards is an evidence based model of care and interaction on mental health wards. Some wards were further ahead with this than other wards but we saw some good examples of this model in practice and the way it was being used on Parkland and Melrose wards. For example, on Melrose ward, there was a board displaying patients' drawings and things they wanted to staff to know about them in their own words. One person had chosen to write where they were from, what their ambitions were and achievements that they were proud of. When we were on the ward, patients approached us to talk about what they had written on the ward. We saw that this created a positive environment and was something that patients were proud of.

Skilled staff to deliver care

- Multi-disciplinary teams on the wards consisted of medical and nursing staff as well as social workers, occupational therapists, clinical psychologists and activities coordinators. There were pharmacists based within the service who visited the wards regularly and were able to provide input to staff and patients.
- We spoke with some nursing staff including health care assistants (HCAs) who had started in the service since

Are services effective?

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

our last inspection in June 2015. They told us that they had completed comprehensive inductions when they started in the service. One HCA told us that they had completed their care certificate.

- Some staff on Parkland ward told us that they had not had consistent clinical supervision in the twelve months prior to the inspection between June 2015 and July 2016. We discussed this with the ward manager. They told us that while supervision for nursing staff was up to date at the time of the inspection, there had been gaps over the previous year where the staffing levels had been stretched. They told us the reflective practice group was regarded as supervision. We asked for numbers regarding supervision over the previous year, however, the ward manager told us that this information was held centrally and that on the wards it was only possible to obtain information which was more recent, for example, about the previous month or two. This meant that it was not possible to have an oversight on the ward about where there might be gaps in supervision if it had not taken place for over a month.
- Nursing staff had access to a weekly drop in reflective practice group which was held on site. Some staff told us that they found this helpful. However, some staff told us that it was difficult to take time from the wards to attend when they would like to.
- Some staff told us that they had access to specific specialist training. For example, staff on Parkland ward had had specific training around working with people who have been diagnosed as having personality disorders. One member of staff told us that the trust offered good support for training and had opportunities for leadership and management training. However, some HCAs told us that they were disappointed by the lack of opportunities available through the trust secondment scheme to help HCAs train as nurses.
- Staff across the service told us they had been given opportunities to attend specific 'learning lessons' events which were open across the trust and this had raised awareness of incident reports and outcomes so that learning could be embedded.
- The service ran monthly education sessions which were open to all staff from all disciplines. These were often on specific issues which were key to the unit. For example, there had been a session on setting appropriate boundaries.
- Each ward had regular staff meetings as well as clinical improvement group meetings which ran either by ward

or pairs of wards. For example, Melrose and Parkland had one clinical improvement group. These meetings picked up issues such as incidents, complaints and feedback. This information was reported to a service wide clinical improvement group to capture themes and areas of concern and excellence so that this information could be disseminated.

Multi-disciplinary and inter-agency team work

- Each ward had either weekly or fortnightly ward rounds where the multi-disciplinary team met and discussed with patients and their families, when appropriate, the current or future treatment plans.
- There was psychology input available on all the wards with five clinical psychologists working across the service. As well as running groups and individual psychology sessions with patients, they also worked with staff to formulate plans to meet the needs of individual patients.
- We observed two nursing handovers. We saw that information from handovers was recorded so that staff could refer to it. Risks were identified and updates related to current issues regarding each patient were discussed comprehensively. Staff worked across three shifts with early, late and night shifts.
- Social workers in the service covered two wards each. They were employed by the local authority and seconded to the trust and led on areas such as safeguarding and liaising with family and carers as well as linking to relevant multi-agency public protection arrangement (MAPPA) which were in place in the local areas that patients came from. This meant that the links between the local authority and the trust were strengthened. As the women's enhanced medium secure service (WEMSS) received referrals nationally, staff within the service liaised with teams across the country. This created challenges when there were numerous services to liaise with but staff ensured that information was shared and that home authorities had relevant information about people in their care.

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

- There was a Mental Health Act office based on the site covering all the services at St Bernard's Hospital. They had co-ordinators in place who scrutinised Mental Health Act documentation on site.

Are services effective?

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

- The Mental Health Act office carried out regular audits on the wards of Mental Health Act paperwork to ensure that it was completed appropriately. For example, the service had undertaken a recent audit on consent to treatment at The Orchard. This was not available at the time of our inspection.
- We reviewed eight records centrally at the Mental Health Act office and found that they were all complete and evidenced that patients' had their rights explained to them regularly and that this was recorded.
- During this inspection, we carried out one Mental Health Act visit on Aurora ward. This meant that we looked specifically at how the Mental Health Act was implemented and checked paperwork specifically which related to the Mental Health Act. Generally, we had positive feedback about this ward. We saw that staff explained to patients their rights on admission and this was repeated and documented regularly. We saw that detention papers were available and in good order and while specific certificates of consent and of second opinion were present in the records where necessary, on two of the records we checked where the information relating to the certificates of second opinion were not complete on the medication charts reviewed.
- Staff on the ward had a good understanding of the use of the Mental Health Act and knew where to seek advice if necessary.

Good practice in applying the Mental Capacity Act

- The trust had recently started to roll out mandatory training related to the Mental Capacity Act. Some staff had not yet completed this but were booked to attend.
- Generally we saw that staff had a good understanding of the principles and practical implementation of the Mental Capacity Act and how it would relate to practice on the wards.
- We saw some good examples of the use of the Mental Capacity Act in the case notes for patients on Pearl ward. However, as decisions made with reference to the Mental Capacity Act were not recorded consistently, this meant that the thoughtfulness and consideration given when assessing capacity about specific issues might not be immediately apparent without looking through the daily records for a patient.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- During our inspection visit we spoke individually with 38 patients across the wards. Most feedback we received was positive and patients spoke positively about the service and the support which they received from staff. Some examples of comments we received included that patients felt listened to and that they felt safe. Some patients raised particular issues such as difficulties in staffing levels. Seven patients told us that wards were short staffed at times and that this had impacted their leave arrangements by being cancelled or postponed.
- We observed staff working positively with patients and displaying care and attention to ensure that they responded with kindness and respect.
- Staff on all the wards we visited demonstrated a very good understanding of the individual needs of patients on the ward. As many patients had been on the wards for extended periods of time, this meant that staff and patients were better able to get to know each other.

The involvement of people in the care that they receive

- The service was developing a welcome pack for patients admitted. Some wards, for example, Parkland, had developed buddying systems so that when patients were first admitted they would be matched with another patient to provide advice and information in addition to the information provided by staff to help them to settle on the wards.
- All wards had weekly community meetings. These meetings were recorded and both staff and patients attended these meetings. They gave patients the opportunity to feed back to the ward community about issues of concern and interest. We reviewed minutes from these meetings on some of the wards which we visited and saw that they were used by a variety of patients and that feedback was welcomed and followed up on.

- Each ward had a daily planning meeting where staff and patients discussed plans and activities which were taking place on that specific day. Patients told us that they found these meetings helpful.
- There was an Orchard patient's forum which met monthly. There were representatives from each ward as well as members of staff across the service including senior management. This was an opportunity for patients to feed back about the services and also to be updated on information from the trust. These meetings were recorded and actions were developed with timescales so that patients were aware that issues raised would be followed up. We saw minutes from these meetings and saw examples where issues raised were picked up. For example, we saw that one patient had raised concerns about the availability of the bank when there were not enough staff and in response to this feedback, a safe was being installed on the ward.
- Most patients we spoke with told us that they were involved in their care planning. We saw evidence of this on the wards we visited and we saw that care plans reflected the patient voice.
- The service was working on collaborative care planning and we saw that some patients had been involved in chairing their own CPA meetings. The ward rounds we observed showed that patients were given the opportunity to share their views. Some patients wrote down what they wanted to say in their ward round in advance. This meant that the meetings and teams were trying to involve people as much as possible in their own care planning.
- The trust produced a magazine across the West London Forensic Service. This was produced with input from service user consultants who worked with the trust and patients on the ward. We saw that contributions had been made to the magazine by patients at The Orchard and one patient spoke very proudly of the work they had produced for the magazine, emphasising its value.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- The service at The Orchard was split into different types of wards. Parkland and Melrose were part of the enhanced medium secure service which accepted patients across England. Aurora, Garnet and Damson wards were medium secure services with Damson focusing more on longer term rehabilitation and Aurora being an admission ward. Pearl was a low secure ward. Aurora, Garnet, Damon and Pearl wards had a catchment area which covered North West London. Pathways into and out of the service varied.
- For admission to the WEMSS service, there was an admission panel which met on an as needed basis. This panel discussed admissions and included the chair who was chaired by a consultant forensic psychiatrist and included a senior nurse and a member of staff from another discipline, for example, a psychologist.
- Referrals were received into the services at the site from other forensic and acute or intensive care wards or through the criminal justice system. Patients were not admitted to the service if there were not sufficient beds and beds remained available when patients were on leave. The service had a draft admission policy which it was due to implement shortly after our inspection visit. We saw that the policy was clear about the criteria, process and exclusion criteria for the service.
- Between 1 January 2016 and 30 June 2016, there were three delayed discharges within these services. There was one on Melrose ward, one on Parkland ward and one on Pearl ward.
- Average lengths of stay varied between the wards. Parkland and Melrose had the highest average lengths of stay at about two years (625 days for Melrose and 663 days for Parkland). Whereas Aurora had an average length of stay in the six months between 1 January 2016 and 30 June 2016 of nearly one year (347 days). The ward with the longest average length of stay was Damson ward which was a slow stream rehabilitation ward and between 1 January 2016 and 30 June 2016 had an average length of stay of 1060 days.

The facilities promote recovery, comfort, dignity and confidentiality

- The Orchard was opened as a purpose-built facility in 2007. Bedrooms across the service were ensuite. Each

- ward had a clinic room and there were rooms on the ward for meetings and activities, as well as The Atrium which was a central area which was accessible to patients on all wards and had a primary healthcare centre as well as rooms which could be used for therapeutic and recreational activities.
- The Atrium was the centre of some vocational work including a cafe, shop and library which patients were able to access but also to develop work experience. There were also some vocational groups such as a textiles group and a group where patients made toiletries like soap and bath bombs to sell.
- The Atrium also offered a drop-in service for advocates who also visited wards for those who were unable to come to the Atrium. There was also a hairdresser's salon. However, the Atrium was only open in the morning and in the afternoon activities took place on the wards.
- Some patients, particularly on Parkland ward, told us they did not have enough ward-based activities as some of them were not able to leave the ward due to leave arrangements. Three patients told us they would like more activities, particularly at the weekends.
- Four patients specifically told us that they were unhappy with the food and three patients told us that they liked the food. The service had changed the catering contract recently. There was a user and staff focus group which was specifically gathering feedback about menus and food which would feed into potential improvements.
- Families were able to visit patients in a room which was off the wards. There was a separate area for children and young people to visit family members in the unit. This had some toys available to make it more appropriate for young people.
- Each ward had a quiet area. Some wards had de-escalation rooms. We talked with patients who used de-escalation rooms and some told us that they found it helpful to have a low stimulation room. They understood that this was different from seclusion as they could choose to leave.
- On Parkland ward there was a sensory room which patients could benefit from with staff members present.
- All wards had secure lockers for patients' belongings.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

- We saw that bedrooms had been personalised according to the preferences of patients where they had chosen to. For example, on Melrose ward, we saw a room which had lots of photographs and pictures which belonged to the patient in the room.

Meeting the needs of all people who use the service

- There were bedrooms available across the wards, which were able to be used for people with limited mobility. While Parkland and Melrose ward were on the first floor, there was access by lift if necessary.
- The service had a chaplain who visited twice a week. However, they could provide additional support if necessary.
- There was a multi-faith room available in the Atrium which patients who had leave granted could visit. Where possible, staff facilitated leave for religious events.
- Staff knew how to contact interpreters and translation services when necessary. We saw that one patient had access to an interpreter for meetings and that this was followed up by ward staff.
- Patients had access to a variety of menu options including halal food and culturally appropriate food.

Listening to and learning from concerns and complaints

- Between 1 July 2015 and 30 June 2016, there were 15 formal complaints to the service regarding wards at The Orchard. Of these, three were fully upheld, two were partially upheld and ten were not upheld. No complaints were referred to the ombudsman. Five complaints related to Melrose ward, four to Aurora ward and three related to Parkland ward.
- The main themes of complaints related to issues around care and treatment as well as poor staff attitude.
- During our previous inspection in June 2015, some patients told us that they did not feel comfortable making complaints. During this inspection, Patients we spoke with told us they were aware of how to complain and felt that they would be able to complain or could approach the advocate for support.
- Information about how to complain was available on the wards.
- Complaints were discussed by the ward team at the clinical improvement group meetings so that they could be used to improve the service.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Staff were able to access the trust vision and values through the intranet and information provided to staff by the service. The values, which were 'togetherness, excellence, caring and responsibility', were reflected in the work that we saw staff do on the wards. There was a commitment from staff we spoke with to involve patients and to provide a good quality service. The Orchard also had a specific five year vision which had developed from a staff away day. We saw the paper that had been developed from this and it reflected plans which worked on the improving the service for patients and valuing the staff working within the service.
- At our last inspection in June 2015, we had mixed feedback from staff in the service about support from the trust and senior management. During this inspection, staff we spoke with were generally positive about their work experiences and working for the trust. They told us that the senior management team including the trust board were more visible and available. There was a good awareness of the senior management in the service and across the trust. This was an improvement since the last inspection.

Good governance

- Since the last inspection in June 2015, there had been some changes in the management team within the service with a new interim clinical director having been appointed.
- Each ward or pair of wards had specific clinical improvement group meetings where clinical governance was discussed. This meant that complaints and incidents were reported and information was fed back to staff at these meetings.
- Some ward managers were new to post and there was an acting ward manager on one ward. However, staff were positive about the changes in ward management and were supportive of their managers. This was an improvement since the last inspection.
- Data for training, supervision and local audits were collated at a ward level so that ward managers were aware of gaps. On Parkland ward, the manager told us that supervision had not been taking place regularly earlier in the year but was back on track at the time of

our visit. This meant that there was a risk that all clinical staff had not received clinical supervision regularly. Staff told us that while the reflective practice group could be counted as supervision, they were not consistently available to attend due to priorities on the ward relating to patient care.

- There was a service specific risk register. We spoke with the lead nurse and clinical lead for the women's forensic service as well as the clinical director across the forensic service. They had a good understanding of the current risks and strengths within the service which reflected what we found on the ward and what patients and staff told us through the inspection visit.

Leadership, morale and staff engagement

- During our last inspection in June 2015, staff told us that they felt undervalued and they reported to us that their morale was poor. Some staff spoke to us about bullying. Since our last inspection in June 2015, the service had put considerable energy into improving staff engagement and morale. There had been some changes in the management team. Most staff with spoke with were positive about this and felt that there had been an improvement in morale over the previous year. This was an improvement since the last inspection.
- A staff forum had been established and ran monthly. This was open to all staff and staff we spoke to throughout the service were aware of it and told us they felt able to attend if they wished to. After each of the staff forum meetings, the service produced a newsletter which was distributed to all staff. We saw some examples of the newsletter and they provided information about additional support staff could access and work that had taken place to improve engagement. This newsletter also included updates from the patient forum where patients wanted information to be fed back and also had some information about recent incidents across the service where lessons had been identified which could prevent further occurrences. This was very positive.
- During our last inspection in June 2015, staff had told us that they did not feel confident raising concerns internally. The service lead and clinical lead had established a confidential email for staff to raise concerns or contact them about any matters. This ensured that the service management were open to staff who wished to communicate in different ways.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Staff sickness across nurses and HCAs at the Orchard was an average of 3.7% between 1 July 2015 and 30 June 2016. The highest level was 5.3% on Pearl ward and the lowest was 2.3% on Damson ward. This was lower than the figures across all forensic services for the same period which was 5.9%.

Commitment to quality improvement and innovation

- At the time of our previous inspection, some wards had started to work on the 'safe wards' project to reduce the use of physical interventions and restrictive practices on the wards. During this inspection we saw that wards had implemented additional work around this project which had been very positive. Patients told us that they liked some of this work, for example, the board on Melrose ward where each patient on the ward had reflected what they wanted staff and visitors to the ward to know about them. This promoted and reflected work on

patients' self-identified strengths and helped contribute to a community environment. Staff told us that this was being developed with the idea that staff would contribute to the ward in the future. This was an improvement since the last inspection.

- We saw that the service had also implemented and developed work on 'soft words' where language was discussed in relation to work with people on the wards and the impact that it could have, for example, not using terms like 'attention-seeking behaviour' and rather seeking to understand people as individuals.
- The service was beginning to look at implementing quality improvement projects. This was not in place at the time of our inspection but there had been some initial work to progress this work through the trust, including this service.
- The Orchard is a member of the Quality Network for Forensic Mental Health Services and had a review of their services in September 2015.

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

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patients.

This was because despite efforts to employ more nurses, there were gaps so that all patients were not regularly able to access planned escorted leave and did not have access to therapeutic activities.

This requirement was stated in the last inspection in June 2015 and is a continuing breach.

This was a breach of regulation 18(1).

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

The provider had not ensured that systems and processes were established and operated effectively to prevent abuse of patients.

This was because seclusion was not consistently recorded appropriately which meant that there was no clear record that relevant monitoring had taken place during episodes of seclusion.

This requirement was stated in the last inspection in June 2015 and is a continuing breach.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 13 (1) (2) (4) (b)