Battersea Bridge House

Quality Report

1 Randall Close
Battersea
London
SW11 3TG
Tel: 0207 924 7991
Website: http://www.inmind.co.uk

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

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

We gave an overall rating to Battersea Bridge House of **good** because:

- The hospital maintained safe staffing levels. Medical cover was available at all times. Pre-employment checks were conducted prior to staff commencing their employment. Staff completed mandatory training and received regular managerial supervision. Care plans were up to date, holistic and recovery-orientated. Care and treatment records were maintained. An appropriate range of disciplines made up the multidisciplinary team and regular team meetings were held. A timetable of clinical audits had been developed and was used to monitor and improve services.
- Staff completed risk assessments and these were updated regularly. Staff reported safeguarding concerns appropriately. There were effective working relationships with outside stakeholders (for example, GPs, care co-ordinators and commissioners). We observed responsive, respectful interactions between staff and patients. There were effective governance systems to monitor key performance areas. Staff morale was good and there was strong local leadership.

However:

- A number of ligature points had been identified and while local measures were used to manage and mitigate risks, work to address the risks was required. No date had been fixed for the work. (Ligature points are places to which a patient intent on self-harm might tie something to strangle themselves.) A number of environmental concerns had been placed on the hospital's risk register, including frequent water leaks, bacteria in the hospital's water system and problems with door locks.
- Staff had not recorded some regular observations of patients in seclusion. While arrangements for ordering, storage and disposal of medicines were safe, an audit in December 2014 identified 27 errors. Some patients who had received rapid tranquilisation had not had their physical health checked appropriately.
- The hospital had developed a complaints policy and procedure but information on how to make a complaint was not displayed. Not all information relating to an individual complaint was readily accessible.
- The majority of staff did not feel there was a clear connection between the provider's corporate managers and the hospital. There were no structures at a corporate level for staff to share learning from incidents across hospitals.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards	Good	We gave an overall rating to Battersea Bridge House of **good** because: • The hospital maintained safe staffing levels. Medical cover was available at all times. Pre-employment checks were conducted prior to staff commencing their employment. Staff completed mandatory training and received regular managerial supervision. Care plans were up to date, holistic and recovery-orientated. Care and treatment records were maintained. An appropriate range of disciplines made up the multidisciplinary team and regular team meetings were held. A timetable of clinical audits had been developed and was used to monitor and improve services. • Staff completed risk assessments and these were updated regularly. Staff reported safeguarding concerns appropriately. There were effective working relationships with outside stakeholders (for example, GPs, care co-ordinators and commissioners). We observed responsive, respectful interactions between staff and patients. There were effective governance systems to monitor key performance areas. Staff morale was good and there was strong local leadership. However: • A number of ligature points had been identified and while local measures were used to manage and mitigate risks, work to address the risks was required. No date had been fixed for the work. (Ligature points are places to which a patient intent on self-harm might tie something to strangle themselves.) A number of environmental concerns had

Summary of findings

been placed on the hospital's risk register, including frequent water leaks, bacteria in the hospital's water system and problems with door locks.

- Staff had not recorded some regular observations of patients in seclusion. While arrangements for ordering, storage and disposal of medicines were safe, an audit in December 2014 identified 27 errors. Some patients who had received rapid tranquilisation had not had their physical health checked appropriately.
- The hospital had developed a complaints policy and procedure but information on how to make a complaint was not displayed. Not all information relating to an individual complaint was readily accessible.
- The majority of staff did not feel there was a clear connection between the provider's corporate managers and the hospital. There were no structures at a corporate level for staff to share learning from incidents across hospitals.

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Services we looked at

Forensic inpatient/secure wards

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Background to Battersea Bridge House

Battersea Bridge House is provided by Inmind Healthcare Group. The service is registered to provide the following regulated activities:

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

• diagnostic and screening procedures

• treatment of disease, disorder or injury.

Battersea Bridge House offers low secure inpatient forensic services to men aged 18 and over with severe mental illness and additional complex behaviour. The service has 22 beds in three wards and 20 of these are block purchased by NHS England. This means the majority of patients are placed at the hospital and funded by the NHS.

Browning ward has 10 beds and is an admission ward. Hardy ward is a six-bed step down ward. Blake ward also has six beds and is a pre-discharge ward. During our inspection, Browning ward was providing care and treatment for nine patients. Hardy and Blake wards were each providing care and treatment to six patients.

All 21 patients receiving care and treatment at the time of our inspection were detained under the Mental Health Act.

Battersea Bridge House has been registered with the CQC since December 2010. There have been three inspections (the most recent being on 22 October 2013). At that time, the hospital was meeting essential standards.

Our inspection team

Team leader: Lea Alexander, Care Quality Commission.

The team that inspected Battersea Bridge Hospital consisted of six people: a CQC inspector, a CQC assistant inspector, an inspection manager, a nurse specialist advisor, a Mental Health Act reviewer and an expert by experience. The expert by experience is a person who has developed expertise in relation to health services by using them.

Why we carried out this inspection

We inspected this service as part of our comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of 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?

Before the inspection visit, we reviewed information that we held about the service, asked a range of other organisations for information and sought feedback from staff.

During the inspection visit, the inspection team:

- visited all three wards at the hospital site, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 11 patients who were using the service

Summary of this inspection

- spoke with the nursing co-ordinators for each of the wards
- spoke with 15 other staff members, including a doctor, nurses, support workers and a social worker
- spoke with the hospital manager
- observed a handover meeting
- observed a ward review
- observed a multidisciplinary team meeting
- carried out a Mental Health Act monitoring visit on Browning ward.
- looked at the care and treatment records of nine patients
- carried out specific checks relating to medication management on three wards
- received feedback about the service from commissioners
- received information from an independent mental health advocate
- looked at records, policies and documents relating to the running of the service.

What people who use the service say

- We spoke with 11 patients. They told us they felt safe on the wards and spoke positively about staff. Patients generally felt well supported. Patients also said they felt able to speak to staff. Some patients felt listened to and included in decisions about their care and treatment while others did not.
- Patients were treated with respect and there were regular meetings to involve patients in the day-to-day running of the hospital. Where appropriate, family members and carers were involved decisions about the care and treatment of patients.
- There was a range of activities available and good access to psychology services. Some patients said there were not always enough staff on duty. Some patients also said they would like to see an improvement to the hospital's garden so that time outside was more pleasant.
- A survey by the provider carried out in 2014 indicated that patients were satisfied with most aspects of care and treatment. The most positive ratings were scored on the topics of nursing staff, safety on the unit, information, cleanliness and activities, where satisfaction scores in excess of 87% were achieved.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- A number of ligature points had been identified on each ward and whilst local measures were in place to manage and mitigate these, work to address the risks was required. No date had been fixed by which to carry out the required work, which meant that patients could be at risk.
- A number of environmental concerns had been placed on the hospital's risk register, including frequent water leaks, bacteria in the hospital's water system and issues with door locks. Local measures had been put in place to mitigate and manage the potential risks. However, building works were required and plans to carry out this out with timescales, were not in place.
- There were no structures at a corporate level for staff to share learning from incidents with other hospitals run by the provider .
- We reviewed a sample of care records for patients who had recently been treated in seclusion and found that during one episode of seclusion regular observations had not been recorded.
- Whilst overall, there were safe arrangements in place for the ordering, storage and disposal of medicines, an audit in December 2014 identified 27 errors relating to MHA documentation, prescription recording errors and patient detail errors. The hospitals review of rapid tranquilisation incidents identified that on two occasions between July 2014 and May 2015 physical observations had not been completed as required for patients who had received rapid tranquilisation. This meant that the patient's health could be at risk.

However:

- The ward layouts allowed staff to see all areas. Wards, bedrooms and communal areas were visibly clean and had reasonable furnishings. Appropriate alarm and call systems were in use. A seclusion room was used in accordance with the hospital's policy and procedure. The seclusion room allowed clear observation, two-way communication and had toilet

Summary of this inspection

facilities and a clock. Staff had completed training on physical interventions. Staff used de-escalation techniques, and restraint, rapid tranquilisation and seclusion were used as last resorts.

- The hospital maintained safe staffing levels. Regular bank staff were used to cover shifts when required. Nursing and healthcare vacancies had been filled or staff were being recruited. Staffing levels could be increased according to the needs of patients. Patients' leave was rarely cancelled and patient feedback regarding activities was positive.
- Appropriate medical cover was available at all times. Appropriate pre-employment checks were conducted prior to staff commencing their employment. Staff completed mandatory training. Staff completed risk assessments and these were updated regularly. Blanket restrictions on patients' freedom were used only when justified. Staff reported safeguarding concerns appropriately. The hospital had a structure for reporting incidents and sharing learning from these across the hospital.

Are services effective?

Good

We rated effective as **good** because:

- Patients were comprehensively assessed on referral and timely assessments were completed on admission. This included a full physical examination. Patients with ongoing physical health conditions had been referred to specialist health care services. Care plans were up to date, holistic and recovery-orientated.
- Appropriate care and treatment records were maintained. These were readily accessible. Staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions. Patients were able to access psychology services. An appropriate range of disciplines made up the multidisciplinary team and regular team meetings were held. A timetable of clinical audits had been developed and was used to monitor and improve services.
- Staff were appropriately experienced and qualified. They received mandatory training and training specific to the core service. Managers supervised and appraised staff's work performance regularly. There were effective working relationships with outside stakeholders (for example, GPs, care co-ordinators and commissioners).

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- Staff demonstrated a good understanding of the Mental Health Act (MHA), code of practice and its guiding principles. Administrative support and advice on the implementation of the MHA and its code of practice were available on site. Detention papers were correctly filled in, up to date and stored appropriately. Advocacy services were available on site. Staff had received training in and displayed a good understanding of the Mental Capacity Act and its statutory principles. Patients were presumed to have capacity to make day-to-day decisions relating to their care. Where capacity was in question, this was assessed and recorded on a decision-specific basis.
- For most patients, records showed that their rights were explained to them at least every month. However, for one patient their care records stated that they had not understood their rights when they were explained to them. There was no evidence of this patient having their rights revisited.

Are services caring?

Good

We rated caring as **good** because:

- The hospital's admission process informed and orientated patients to the ward and service. In a patient satisfaction survey, 87% of patients rated the staff positively. We observed responsive, respectful interactions between staff and patients. Staff demonstrated compassion and genuine feeling about the patients they supported. The staff team knew the patients and their holistic needs. A small number of patients were placed outside of their geographical locality. They said that where they had requested the involvement of families or carers staff had supported them with this.
- Sampling of care records showed that patients were routinely involved in their care planning. Care plans were mainly written in clear and accessible language. Patients attended ward reviews and care programme approach (CPA) meetings to participate in planning for their care. Some patients had advance directives in place.
- Patients were aware of advocacy services and in some cases had received support from them. Information relating to advocacy services was displayed throughout the hospital. Weekly community meetings were well attended by staff and patients. A summary of actions from community meetings was displayed on noticeboards around the hospital. Occupational therapy staff were working with patients to develop ways that they could be involved in recruiting and interviewing new staff.

However:

Summary of this inspection

- Whilst the majority of care plans recorded patient involvement in their development and review, for one long-term patient there was minimal evidence of their involvement. No reasons for this had been recorded.

Are services responsive?

Good

We rated responsive as **good** because:

- There were no delayed discharges. Admissions to the hospital were planned and did not take place outside normal working hours nor, where possible, on a Friday. Staff prepared patients when new admissions were expected and supported patients when their peers were discharged. Where patients were placed out of their geographical area, responsibility for their care had transferred to the local authority in the hospital area.
- Where patients had been granted leave, a bed was always available for them on their return. Patients were not moved between wards during a stay in hospital unless this was justified on clinical grounds. Discharge meetings were held prior to discharge and plans and summaries were produced in advance of a patient leaving the service.
- A full range of rooms was available to support care and treatment and a good range of therapeutic activities was available. Patients were able to personalise their bedrooms and were provided with somewhere secure to store their possessions. Staff were able to access interpreters when required.

However:

- Whilst a patient kitchen was available, this was locked and some patients commented that they were not able to use this kitchen regularly and were not therefore able to develop their self-care skills before discharge. The unit had an outdoor area but from the outside the fencing identified the hospital as a secure mental health facility and efforts could be made to improve privacy for patients.
- Staff used patients' bank cards and personal identification numbers (PINs) to withdraw money on their behalf because they could not go to the bank themselves and did not want their money held in the hospital account. This was a risk for both patients and staff.

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- The hospital had developed a complaints policy and procedure but information on how to make a complaint was not displayed. Not all information relating to an individual complaint was readily accessible or attached to the record of the complaint.

Are services well-led?

Good

We rated well led as **good** because:

- There were effective governance systems to monitor key performance areas, including mandatory training, managerial supervision and performance appraisal, and staff deployment. Performance data was monitored to identify key themes and trends, and appropriate actions taken to deal with any issues. A risk register was used to identify risks and actions taken to remove or mitigate them.
- Staff morale was good and there was strong local leadership.

However:

- The majority of staff did not feel there was a clear connection between the provider's corporate managers and the hospital.
- While the hospital manager generally had sufficient authority for their role, they did not have control over a local budget that could be used to maintain and improve the environment. Where maintenance work was required, this required approval at a corporate level, which had led to delays in some building work being done.

Detailed findings from this inspection

Mental Health Act responsibilities

- We carried out a Mental Health Act (MHA) review visit to Browning ward as part of the comprehensive inspection. We also looked at some aspects of the MHA whilst visiting Blake and Hardy wards.
- Staff demonstrated a good understanding of the MHA, Code of Practice and guiding principles.
- For most patients it was demonstrated that their rights were explained to them at least every month. However, for one patient their care records stated that they had not understood their rights when they were explained to them. There was no evidence of this patient having their rights revisited.
- There was a standardised system for authorising leave and leave authorisations clearly identified any specific conditions that applied. Records of capacity and consent to treatment were located on each patients care records. Certificates showing that patients had consented to their treatment (T2), or that it had been properly authorised (T3), were completed where required and on Browning ward were attached to medicine charts.
- Administrative support and advice on the implementation of the MHA and its code of practice were available on site through the local MHA office. Detention papers were correctly filled in, up to date and stored
- An independent mental health advocacy (IMHA) service was available to patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff members were compliant with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Patients were involved in decision-making as far as possible. No patients were subject to Deprivation of Liberty Safeguards at the time of our inspection.

Good

Forensic inpatient/secure wards

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are forensic inpatient/secure wards safe?

Requires improvement

Safe staffing

- At the time of our inspection, Battersea Bridge House had vacancies for two nurses. These had both been recruited to, with start dates confirmed. In addition, four support worker vacancies had been identified. Two of these had been recruited to, with staff due to start. The remaining two vacancies were being advertised.
- During the day, there was a minimum of three qualified nurses and six healthcare assistants on duty. At night, there were two qualified staff members and four healthcare assistants on duty. Staff were deployed as required on a daily basis across the wards depending on activities and patient need.
- This meant that on some wards, for example Hardy or Blake, a qualified nurse was not always sited on the ward during the day when the majority of patients would access the facilities and services on other wards. A support worker could on occasion be lone working on this ward. We were told that this was risk assessed and reviewed as it occurred. We were also told that the hospital had a lone working policy to address this and that the member of staff was issued with a radio to keep in regular contact with staff deployed on other wards. Staff we spoke with confirmed these arrangements and told us that they felt safe.
- Overall staffing levels had been estimated using a recognised tool and were adequate to meet the needs of patients. Staff told us that safe staffing levels were maintained and that it was rare for bank staff to be used, usually only to cover unexpected staff absences such as sickness.
- The number of staff on duty reflected the rota on the day of our visit. The hospital manager advised that there was usually one shift per week where they were not able to meet establishment for a shift. Bank staff would be approached to cover this where possible, then agency staff. If the shift could not be covered through these means then the available staffing complement would be deployed as necessary to meet patient needs safely.
- The hospital manager was able to increase staffing levels according to the needs of the patients being supported on the wards, for example when patients required increased nursing observations or due to leave requirements.
- Patients received regular one to ones with their named nurse.
- Patients had access to regular leave and it was rare this would be cancelled. There were occasions when staff would negotiate with patients as to when leave might happen, for example if long leave were not possible on one day it would be offered and facilitated the following day. There were a number of activities available on the ward, including gym equipment. These enabled patients to increase their independence as part of their continued recovery. Patient feedback regarding activities was positive.
- During the day, there was a consultant psychiatrist available, giving adequate medical cover. The consultant was on call at night and during weekends and would go into the hospital as required.

- We reviewed the hospitals audit of personnel files for staff working in the service. This showed that checks were carried out on staff before they started working in the service to confirm that they were suitable to work with patients. These included checks with the disclosure and barring service, two references from previous employers and photographic proof of identity. The service checked prospective employees' qualifications and where appropriate their professional registration.
- The provider had identified a range of mandatory training. This included the management of violence and aggression, the Mental Health Act, first aid, breakaway, medicines management, rapid tranquilisation, relational security, safeguarding, infection control, health and safety and information governance. At the time of our inspection, the hospital was showing as exceeding its target of 80% completion of mandatory training by permanent and bank staff.

Assessing and managing risk to patients and staff

- We reviewed the care records of nine patients across all three wards. These evidenced that staff completed risk assessments on admission and regularly updated these. Where particular risks had been identified, management plans were put in place to support the patient to manage the issues. The historical clinic risk (HCR 20) tool was used to assess and manage violent risks. We observed a risk summit being held by the multidisciplinary team during our visit, where identified risks and management plans were reviewed. Risk assessments were also reviewed during each ward round.
- Staff audited risk assessments regularly to ensure they had been completed and updated. From January to March 2015, 100% of HCR 20 risk assessments had been completed within three months of admission. Staff reviewed and updated HCR 20 risk assessments regularly. In-house risk assessment training was developed and delivered to all staff in May 2015. Patients took part in delivering this training.
- Blanket restrictions were only used when justified. There were robust systems to monitor and review the use of restrictions at ward and patient level.
- Some blanket restrictions were used. For example, carrier bags were banned from the ward due to the potential risk they could present to individual patients.
- The hospital had identified a range of restrictive practises that were in use including: searches upon return from leave, room searches, random drug screens, internet access, garden leave and restricted items. A blanket policy of searching patients when they returned from leave had recently been changed to a tiered system based on individual patient assessment. This measure was in place to respect the dignity of patients, but also to maintain the safety of the individual and other patients.
- Restrictions on the freedom of individual patients were detailed in their care plans. The reason for each restriction was discussed with the patient. The numbers of restrictions in use on each ward and affecting each individual patient were monitored and rated as red, amber and green. Restrictions for individual patients were regularly reviewed by the staff team.
- All staff completed training on physical interventions and this was refreshed each year. The training included the use of de-escalation techniques. Staff had either completed the training or were booked to attend.
- Audits carried out by staff indicated that from July 2014 to January 2015 there were four incidents of prone restraint in total for two patients. From January to May 2015 a further two incidents of prone restraint were identified, involving one patient. Care and treatment records indicated that there was no use of planned prone restraint with patients. Staff prepared behaviour support plans for those patients at risk of using aggression and violence. This included the identification of triggers and de-escalation techniques that had previously been successful.
- From July 2014 to January 2015 there were eight incidents of patients receiving rapid tranquilisation. From January 2015 to May 2015 there were two incidents of patients receiving rapid tranquilisation. This indicated a downward trend in the use of rapid tranquilisation. We spoke with the hospital manager about this who advised that one patient who had received rapid tranquilisation on several occasions had been transferred to another hospital following a deterioration in their mental state.
- The hospitals review of rapid tranquilisation incidents identified that on one occasion between July 2014 and May 2015 physical observations had not been

completed as required for patients who had received rapid tranquilisation. This meant that the patients' health could be at risk. If an incident of restraint took place over a weekend, the consultant psychiatrist was on call and would respond as needed.

- Staff were trained in safeguarding. The policies and procedures were easily accessible and safeguarding incidents were communicated at handover meetings or earlier. A social worker was attached to the unit and had a clear role where there were safeguarding concerns and worked jointly with clinicians in these circumstances.
- Between 16 April 2014 and 5 July 2015 there were nine occasions when safeguarding concerns had been raised. A database containing an overview of all safeguarding concerns and the actions taken was maintained. This included information detailing the nature of the concern and the actions taken, including referrals to the local authority safeguarding lead, reports to police, updates regarding strategy meetings and the current stage of any ongoing investigation. This record clearly indicated whether the safeguarding concern had been resolved, along with the outcome and any actions, or whether it was ongoing and the current situation.
- In addition, regular safeguarding audits were completed. This indicated that vulnerable patients had appropriate care plans in place, including a risk management plan. The hospital manager had been able to identify themes from safeguarding concerns that included patient on patient violence and aggression and allegations of inappropriate behaviour by staff. Actions to address issues arising from the safeguarding audit were in place, were rated red, amber or green and were being monitored by the hospital manager.
- There were safe arrangements in place for the ordering, storage and disposal of medicines. The service regularly audited medicine records to ensure the recording of administration was complete. A pharmacist attended the ward weekly and on request. Specific training regarding medication or administration was provided by the pharmacist and staff considered them to be an integral member of the MDT.
- The most recent pharmacy audit available was for the period October to December 2014. This included the review of 51 prescribed medicines on Blake ward, 98 prescribed medicines from Browning ward and 44 prescribed medicines from Hardy ward. A total of 27 errors were found over the sample, which included errors in MHA documentation, prescription-recording errors and patient detail errors. Immediate action was taken to address all identified errors.
- In the two reporting quarters January to June 2015, no controlled drugs errors or issues were identified.
- There were rooms available within the hospital for patients to meet with their family.

Track record on safety

- In the last year there had been one serious incident relating to safeguarding. This had been independently investigated, staff were debriefed following the incident and an action plan was developed and implemented.
- As a result of the investigation several improvements had been made to the service including: the proposed use of CCTV in some communal areas; an additional two days training to staff on maintaining professional boundaries and the use of a psychotherapist to facilitate staff group supervision.

Reporting incidents and learning from when things go wrong

- The hospital had a structure for reporting incidents, investigating and cascading the information to share with staff. All incidents that should be reported were reported. Staff gave appropriate examples of incidents they had reported. Reports were sent to the hospital manager and investigated by the most suitable team member. Incident trends were identified, discussed at the multidisciplinary team, clinical governance and handover meetings.
- Staff members received support after a serious incident, including a debrief meeting and opportunities for reflective practice. Incidents were low with only one serious untoward incident reported in the 12 months prior to the inspection. A recent audit of incident reports indicated that post incident debriefs for staff did not always take place.
- At a hospital level there was evidence of incident investigations being shared with staff across all wards

during team meetings, handover meetings and in supervision. However, there were no structures in place at a corporate level for staff to share learning from incidents across hospitals.

- Learning had been identified from a recent incident where a restricted item had been given to a patient, but was not returned. A local working group had reviewed the incident and recommended changes, that were implemented, in the way restricted items were stored, issued and monitored.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Two members of the MDT comprehensively assessed patients who were referred to the hospital prior to admission.
- We reviewed the care records of nine patients across all three wards. These evidenced that comprehensive and timely assessments were completed upon referral and at the point of admission. Detailed assessments and care plans were available for each of the patients whose care records we accessed.
- Each patient's assessment included a full physical examination on admission. All patients were registered with a local general practitioner (GP) for their physical healthcare needs. The GP service provided an on-site clinic at the hospital every two weeks. There was evidence of discussion in MDT and handover meetings of both physical and mental health needs for all patients. Some patients experienced ongoing physical health conditions and had been appropriately referred to specialist health care services for follow up.
- Care plans were up to date, holistic and recovery orientated. In the majority of care plans, there was evidence of patient involvement and comments. Patients confirmed they had been involved in care planning and had been offered a copy of the plan. However, we found one patient who had been receiving care and treatment since 2011 where there their views on the care plan were minimal, with no reasons for this recorded.
- We saw evidence of advance discharge planning for patients, including their social care needs.
- The hospital kept paper record of patients care and treatment. These were accessible and well maintained. This meant staff could gain an accurate picture of a person's care.

Best practice in treatment and care

- Staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions (for example, when prescribing medicines).
- Patients in the service had access to a psychologist and were offered support on an individual basis. The psychology department developed recovery focused programmes to engage patients and these were regularly updated to interest different patients. Thought was given to how to engage those who lacked motivation or had limited insight into their own mental health.
- A physical health care lead had been identified within the hospital and this role was working well as patients physical health care needs were being appropriately assessed and reviewed.
- Staff used recognised scales to assess and record severity and outcomes, for example Health of the Nation Outcome Scales (HoNOS). The occupational therapist used the model of human occupation screening tool (MOHOST) to evaluate the progress of patients.
- Staffs were carrying out wide ranges of clinical audits. A timetable of clinical audits had been developed and implemented. Clinical audits were used by teams and the hospital manager to measure the quality of the service provided and to identify areas for improvement. Audits that we reviewed during the course of the inspection included MHA monitoring, care records, restrictive practises, seclusion, restraint and rapid tranquilisation, food safety, health and safety, safeguarding and infection control. Where particular issues or concerns had been identified because of audit, for example lack of physical observations following

rapid tranquilisation, action plans were in place to address these. Some audits, for example infection control were rated as green as good compliance had been established.

Skilled staff to deliver care

- Staff working in the hospital and making up the MDT included a consultant psychiatrist, nurses, psychologists, a social worker and health care assistants.
- Staff were appropriately experienced and qualified. They received a range of mandatory training and training specific to the core service. Some staff had undertaken specialist training relevant to their role and training sessions in specific areas such as mental capacity and medication administration were regularly organised.
- The hospital aimed to provide annual appraisal and clinical supervision to staff on 8-10 occasions throughout the year. In January 2015, 60% of staff were receiving regular supervision. Since January 2015 the hospital manager had been monitoring the frequency of staff supervision, this included the date supervision had been provided and if no supervision session had taken place the reason for this (for example leave). The records we saw evidenced that from January to July 2015 the maximum number of supervision sessions any individual staff member had received was five and the minimum number of two. Where the lower number of supervision sessions was evidenced the hospital manager was able to tell us the reasons for this, for example sickness or having recently joined the service. With the additional oversight provided by the hospital manager since January 2015, the service appeared on target to provide between 8-10 supervision sessions to staff by January 2016. Monthly statistics were being shared with supervisors to support this.
- Allied health professionals (for example occupational therapists) received managerial supervision from the hospital manager. External supervision and appraisal arrangements were in place for allied health professionals and medical staff. Some allied health professionals had developed informal support networks
- Staff performance issues were addressed through ongoing supervisions. There were no staff performance issues reported at the time of the inspection.
- Regular staff meetings were held and staff encouraged to attend these.

Multi-disciplinary and inter-agency team work

- There were a range of MDT meetings, these were held weekly and led by a senior member of the team. There was evidence these had been designed effectively to not only deliver good care, but also to maximise good use of staff time. Staff reported that the different professionals worked well together. Care records and ward round records evidenced multi-disciplinary input.
- We observed a handover between shifts. There was good discussion of patients' risks to themselves and others and actions required to minimise these risks, as well as a holistic discussion of the patient's needs. Staff demonstrated a high level of care and compassion for patients through their interactions and behaviour in the handover.
- The hospital had identified and maintained contact with care co-ordinators, who were invited to CPA meetings and where appropriate ward reviews. Regular communication was also maintained with identified contacts within NHS England who were the main commissioners of the service.
- There were effective working relationships with outside stakeholders, for example the local GP, with whom all patients were registered. Safeguarding concerns had been discussed and referred to the local authority.
- In addition, the hospital had established links with the Ministry of Justice, who were required to give approval for some care and treatment decisions for patients detained under forensic sections of the MHA.

Adherence to the MHA and the MHA Code of Practice

- A Mental Health Act Reviewer carried out a review of the use of the MHA on Browning ward during the week of the inspection.
- Staff showed a good understanding of the MHA, Code of Practice and guiding principles.
- For most patients it was evidenced that their rights were explained to them at least every month. However, for one patient on Browning ward we found a discussion of rights had been completed on the day of their

admission, a discussion of rights was repeated with this patient after two months that stated the patient had 'not understood'. No further evidence of a discussion of rights could be located.

- There was a standardised system for authorising leave and leave authorisations clearly identified any specific conditions that applied. Records of capacity and consent to treatment were located on each patients care records. Certificates showing that patients had consented to their treatment (T2), or that it had been properly authorised (T3), were completed where required and attached to medicine charts.
- Administrative support and advice on the implementation of the MHA and its code of practice were available on site through the local MHA office. Detention papers were correctly filled in, up to date and appropriately stored. There were regular audits to ensure that the MHA was being applied correctly, and there was evidence of learning from these audits.
- We were told the independent mental health advocacy service (IMHA) was provided by The Advocacy project and they attended the wards community meeting regularly. Posters displayed on the ward, advertised the IMHA service. The advocate visited the ward every month, was contactable in between, and would visit as necessary. Staff and patients were aware of the IMHA service and how to contact them.

Good practice in applying the MCA

- Staff had received training in and displayed a good understanding of the Mental Capacity Act (MCA) and its guiding principles.
- The provider had developed a policy relating to the MCA that staff were aware of and could refer to.
- For day-to-day decisions relating to their care, patients were presumed to have capacity and supported to make decisions. Where capacity was in question, this was assessed and recorded on a decision specific basis.
- Staff knew where to get advice regarding the MCA.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- In a patient satisfaction survey completed in 2014, 87% of patients from all wards, who responded, said they rated the staff positively.
- We spoke with 11 patients. Overall, patients made positive reports about how staff treated them.
- We observed responsive, respectful interactions between staff and patients.
- Staff demonstrated compassion and genuine feeling about the patients they supported. The staff team, including the consultant psychiatrist knew the patients and their holistic needs very well.

The involvement of people in the care they receive

- The hospitals admission process informed and orientated patients to the ward and service.
- We reviewed nine care records. These showed that patients were routinely involved in their care planning. Care plans were mainly written in clear and accessible language. Patients wrote on their care plans and had copies of them. When care plans were reviewed, patients also had the opportunity to record their own comments. Overall, patients felt involved in decisions about their care and treatment.
- Patients attended ward reviews and care programme approach meetings. These ensured patients could contribute to the planning of their care and understand their individual plan for recovery.
- Patients were aware of advocacy services and in some cases had received support from them. Information relating to advocacy services was displayed throughout the hospital.
- The ward had a weekly community meeting. These were well attended by staff and patients and decisions were made about the day-to-day running of the service. The minutes from these meetings were available and typed up with clear evidence of discussions, actions and issues being taken forward and resolved. A summary of actions from community meetings was displayed on notice boards around the hospital.

Good

Forensic inpatient/secure wards

- In addition, daily planning meetings took place between patients and staff to make arrangements about leave and activities taking place that day.
- In a patient satisfaction survey completed in 2014, 87% of patients reported that they were given sufficient information about their care and treatment. However, this figure dropped to a 62% positive response when patients were asked how involved they were in their care and treatment.
- A small number of patients were placed outside of their geographical locality. They reported that where they had requested the involvement of families or carers staff had supported them with this. Other patients reported that their families and carers were involved in their care and treatment where they had agreed to this.
- Occupational therapy staff were working with patients to develop ways that they could be involved in the recruitment and interviewing of new staff members. This work was in progress at the time of our inspection and was not yet in place.
- For some patients, where there had been a history of violence and aggression and nursing in seclusion had been required, advance directives had been developed with patients on how this would be managed. These identified possible triggers and de-escalation techniques to be utilised before nursing in seclusion was considered.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- There were no delayed discharges reported by the hospital in the pre inspection information submitted by the provider.
- Battersea Bridge House provided low secure inpatient services. NHS England commissioned twenty of its 22 beds. In 2014 bed, occupancy fell to 15, but at the time of our inspection had risen to 21. Admissions to the hospital were planned and did not take place out of hours, nor, where possible, on a Friday.
- There was no waiting list of patients to be admitted. Staff prepared patients when new admissions were expected, and supported patients when their peers were discharged. The majority of patients were placed from nearby London boroughs; however, some patients were placed out of their geographical area. Where this was the case, responsibility for their care had transferred to the local authority in the hospital area. The hospital had established and maintained links with identified care co-ordinators.
- Where patients had been granted leave, a bed was always available for them on their return. Patients were not moved between wards during an admission episode unless this was justified on clinical grounds.
- The average length of stay in the service was 18 months. Discharge meetings were held prior to discharge. Discharge plans and summaries were produced in advance of a patient leaving the service. Discharges occurred at appropriate times of the day.
- On occasion, due to a change in their mental state, some patients could require referral to a medium secure setting. Staff told us that on a recent occasion where this had been required, an appropriate placement had been located and a transfer had been arranged.

The facilities promote recovery, comfort, dignity and confidentiality

- A full range of rooms was available to support care and treatment, including a clinic room, activity rooms and a gym that could be accessed with staff support. Visitors could meet patients in private. An occupational therapy kitchen was available, however this was locked and access was facilitated when accompanied by a staff member. Some patients commented that they were not able to use this kitchen regularly and were not therefore able to develop their self-care skills prior to discharge.
- The unit had a secure out door area and this could be accessed with support from staff. However, it was noted from the outside the fencing immediately identified the hospital as a secure mental health facility and efforts could be made to improve privacy for patients. Five

smoking breaks were provided to patients on the wards throughout the course of the day. This number had been reduced, in consultation with patients, in preparation for the hospital moving to a smoke free environment in January 2016. Nicotine replacement therapy was available to patients on request.

- In a patient satisfaction survey completed in 2014, over 87% of patients had responded positively about the activities available at Battersea Bridge House Hospital. During the week, there was a good range of therapeutic activities available on an individual and group basis. Patients we spoke with were generally satisfied with the range of activities available and were involved in planning at the weekly community meeting. We were shown the rota of activities and there was a good range provided and efforts made to involve patients or provide 1:1 when this was preferred. However, some patients did comment that there were not enough activities provided at the weekend.
- An innovative and changing group work programme was available, led by the psychology team and involving the full MDT. This included a programme that had been run twice in which patients created a fictional patient and then followed the process from admission for this patient. This involved role-playing for both patients and staff and culminated in the patients making decisions about the support and types of leave would be most appropriate for the fictional patient.
- A telephone was available for patients to use in the communal areas of the hospital. Staff and patients advised that should they wish to make a private call staff would facilitate this in a private room.
- In a patient satisfaction survey completed in 2014, 75% of patients responded positively about the meals provided. Patients told us that hot drinks and snacks were available in between meal times. Some patients met regularly with the hospital chef to plan the menu.
- Patients were able to personalise their bedrooms, and were provided with somewhere secure to store their possessions.
- There was a practice of taking a patients bank card and pin number to withdraw money on behalf of the person, as they did not have leave to be escorted to the bank and did not want their money held in the hospital account. This was a risk for both patients and staff.

Meeting the needs of all people who use the service

- Patients we spoke with commented that their dietary and cultural requirements were met in the meals provided.
- In the reception area there was information about different services provided at the hospital, including psychology and social work. There was also information regarding care plans and the care programme approach.
- Staff were able to access interpreters when required.

Listening to and learning from concerns and complaints

- The hospital had developed a complaints policy and procedure. However, information on how to make a complaint was not displayed around the hospital either in poster or leaflet form.
- The hospital maintained a log of all complaints received. The log contained details of each complaint received, its investigation and outcome. This included informal or verbal complaints as well as formal complaints. However, not all information relating to the individual complaint was readily accessible within the log, or attached to the record of the complaint. The outcome of complaints investigations was fed back to complainants and the records we saw demonstrated an open and transparent culture.
- Between January 2014 to April 2015, 37 complaints were made to the provider. At the time of our inspection all of these complaints had been investigated, the outcomes fed back and appropriate actions taken. No new complaints had been received.
- Themes identified from complaints included attitudes of staff, the environment and visiting times. The hospital manager was able to describe learning from complaints and how this was being addressed. This included training for staff around promoting professional boundaries and efforts to have identified works approved and funded at a corporate level.

Are forensic inpatient/secure wards well-led?

Good

Forensic inpatient/secure wards

Good

Vision and values

- Staff members were aware of and agreed with the organisations values. The ethos on individual wards reflected the provider's values.
- Some senior staff members knew the corporate level management team and told us they had visited the hospital, but the majority of staff did not feel there was a clear connection between the provider's corporate managers and the hospital.

Good governance

- There were effective systems to ensure that:
  - staff were compliant with mandatory training
  - staff received regular management and clinical supervision and where needed this was arranged externally
  - a sufficient number of staff of the right grades covered shifts
  - staff participated in clinical audit and an annual programme of clinical audits was in place. Information form audits were used to inform and improve the care and treatment provided to patients
  - overall, MHA and MCA procedures were followed and staff understood and followed safeguarding procedures
  - there were clear channels for reporting incidents and escalating risk information, disseminating information and learning and monitoring standards within the hospital, but there was not a system for sharing learning across the organisation.
- The hospital gathered key statistical information each month to gauge the performance of the service. These included a detailed breakdown of:
  - the number incidents and their categorisation
  - details of the numbers of restraints, seclusions and rapid tranquilisations
  - details of the numbers of safeguarding and an indication of whether the investigation had concluded or was ongoing
  - monitoring of supervision, appraisal and mandatory training
  - information about the number of complaints received and how many were yet to be resolved.
- We looked at the monthly breakdown of mandatory training dating back to September 2014. This showed that since February 2015 the provider had met its target of a minimum of 80% of permanent and bank staff having completed mandatory training, with the majority of mandatory trainings being completed by 90% or more of staff and some showing as completed by 100% of staff.
- Since March 2015, over 80% of staff had received an appraisal. Supervision rates each month were lower, with between 36% and 60% of staff receiving supervision each month between January and June 2015. Other monitoring measures were in place to ensure that supervision rates improved and targets were met.
- There were low numbers of complaints each month, with these peaking in February 2015 when three complaints were received. Complaints were appropriately investigated and responded to in a timely manner.
- Vacancy rates for nurses were stable. These had risen from zero in October 2014 to a monthly average of 20%. Vacancy rates for support workers were more variable and fluctuated between a maximum of 35% and a minimum of 10%. In June 2015, the vacancy rate for support workers was 21%. The provider was actively recruiting to all vacancies within the service and appropriate cover from bank staff was available.
- No themes or issues could be identified from the performance information available. Where there were monthly variations the manager was able to describe particular circumstances that had contributed to these and the measures put in place to address them.
- The hospital manager told us that generally they had sufficient authority for their role. However, the hospital manager did not have control over a local budget that could be used to maintain and improve the

environment. Where maintenance works were identified, this required approval at a corporate level, which had led to delays in some building works being carried out.

- A risk register was in place for the hospital. We looked at this and saw that appropriate entries had been made, along with the local and corporate actions required to mitigate and manage these. However, some environmental risks that required building works to address them had been placed on the risk register for some time, in the case of ligatures for over a year, with no clear agreement at a corporate level to fund and implement the required works to address these.
- The Battersea Bridge House risk register was shared with the provider's senior leadership team and fed into a corporate risk register.

Leadership, morale and staff engagement

- Sickness rates were low and averaged 2% each month with a maximum of 6% reached in November 2014.
- Staff knew there was a whistle blowing process and talked about what they would do if they had concerns they did not feel could be raised with managers. This included contacting the Care Quality Commission. Morale was high and staff spoke positively of their colleagues and management team. Staff were open and transparent and demonstrated an understanding of the requirement to explain fully to patients if things went wrong.
- Local leadership was strong with consistently good feedback from staff about the management team. The local management team had a clear understanding of issues raised by the staff.
- There were concerns regarding the leadership provided from the corporate senior team, staff described a disconnect between this team and the day to operation of the hospital.
- The hospital conducted a staff survey in 2014. Thirty-five staff, which represented 70% of the workforce, submitted a response. The majority of areas covered in the survey received a positive rating of 71% or more. The domain addressing the intensity and pressure of work and staff ability to have control over this received the lowest rating at 69%. Ninety two percent of staff stated that their role and responsibilities were clearly defined. Analysis of the staff survey had been completed by the hospital and a range of measures was in place to address issues identified in the staff survey.

Commitment to quality improvement and innovation

- Quality governance meetings identified any key themes from performance indicators and put measures in place to mitigate and monitor these. For example, in January 2015 the quality governance meeting noted an increase in the use of seclusion over the Christmas period. Reasons for this were identified and actions put in place to address. A follow up audit one month later showed a decrease in the use of seclusion that had subsequently been sustained.
- The hospital submitted commissioning for quality and innovation (CQIN) information to NHS England, their main commissioner each quarter.
- We were advised that the hospital was considering joining the Quality Network for Forensic Mental Health Services, but this had not as the hospital were deliberating how best to release staff for the peer review element of the network.
- Battersea Bridge House had established links with a medium secure unit in Scotland. Good practice and learning was shared between the services.

Outstanding practice and areas for improvement

Outstanding practice

- An innovative and changing group work programme was available. This included a programme that had been run twice in which patients created a fictional patient and then followed the process from admission for this patient. This involved role-playing for both patients and staff, and culminated in the patients making decisions about the support and types of leave most appropriate for the fictional patient.
- Restrictions on patients' freedom were applied on a case-by-case basis according to assessed risks. Restrictions were regularly reviewed and monitored using a red, amber and green system. Patients had been involved in delivering in-house risk assessment training to staff earlier in 2015.
- Battersea Bridge House had established links with a medium secure unit in Scotland. Good practice and learning was shared between the services.

Areas for improvement

Action the provider MUST take to improve

- The provider must complete work to remove ligature risks and deal with other environmental concerns, including the hospital's plumbing and water systems.

Action the provider SHOULD take to improve

- The provider should ensure that staff record regular observations for each patient during each episode they are nursed in seclusion.
- The provider should ensure that staff complete and record appropriate physical health observations when a patient is given rapid tranquilisation.
- The provider should ensure that staff keep for each patient accurate records of their status under the Mental Health Act, their personal details and the medicines being prescribed.
- The provider should ensure that structures are developed and implemented to share learning about incidents across different hospital sites. When an incident occurs, staff should be supported to de brief.
- The provider should ensure that patients are involved in the development and review of their care plan and where this is not possible, the reasons for this should be recorded.
- The provider should ensure that where patients have not understood their rights under the MHA this is revisited with them in a timely manner.
- The provider should ensure that information about its complaints procedure is displayed around the hospital and that all complaint investigation records are stored together in the format prescribed by their complaints policy and procedure.
- The provider should ensure that patients are able to access the self-catering kitchen regularly in order that self-care skills can be practised and developed prior to discharge.
- The provider should ensure patients privacy is protected when accessing the hospitals garden and that consideration is given to making the garden a pleasant environment for patients.
- The provider should ensure that appropriate arrangements are in place for patients to access funds from their bank account when they do not have leave in place.
- The provider should ensure that senior managers at a corporate level have a presence within the hospital and understand the demands of providing care and treatment.
- The provider should ensure that the hospital manager has sufficient authority to carry out their role, including management of a local budget for maintenance and improvement of the environment in a timely manner.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The premises used by the provider were not suitable for the purpose for which there were being used and were not properly maintained. Regular environmental audits had identified a number of issues and building works were required to address these. These included the malfunction of the airlock and manual door locks jamming. There had been repeated water leaks throughout the building. The annual test for Legionella carried out in 2014 evidenced the presence of bacteria in the hospitals water system. The hospitals ligature risk assessment identified a range of ligature points throughout the hospital that required replacement. The provider had not scheduled these required works and no timescales were available for when they might be addressed. **This was a breach of regulation 15(1)(b)(c)(e)**