Battersea Bridge House Limited

# Battersea Bridge House

**Inspection report**

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

## Ratings

| | |
|---|---|
| Overall rating for this location | Requires Improvement |
| Are services safe? | Inadequate |
| Are services effective? | Requires Improvement |
| Are services caring? | Requires Improvement |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Requires Improvement |

# Summary of findings

## Overall summary

Battersea Bridge House is a low secure independent hospital in South West London. It provides care and treatment to men aged 18 years and over with severe mental illness and additional complex behaviour.

Our rating of this location went down. We rated it as requires improvement because:

- The service did not have robust governance systems to ensure the quality and safety of the service. Some actions from the previous inspection remained outstanding and it was not clear who had oversight of these or why actions had not taken place. For example, some blind spots remained on the wards.
- Wards were not always safe. There were potential ligature anchor points on all wards. Fifty percent of the staff we spoke to were not aware of any ligature points and the mitigations for these. Staff did not complete and regularly update thorough risk assessments of all ward areas. We did not see evidence of individual risk assessments for patients to access their phones and the internet unsupervised.
- The service did not always have enough staff. Staffing was calculated for the hospital as a whole, as opposed to the individual wards. There were occasions when a ward was staffed by a single support worker. The service had a single consultant providing medical cover at all times. The service did not have a psychologist in post. Patients were therefore unable to access psychological therapy and specialist forensic risk assessments were not being reviewed or updated.
- Mandatory training compliance fell below the service's 80% target in eleven courses. For example, basic life support, mental health act awareness and medication management
- The service did not always comply with corporate policy in relation to infection prevention and control as some staff did not wear protective face coverings. Not all patients on the ward had personal emergency evacuation plans readily available in case of a fire emergency.
- Staff did not always follow systems and processes to prescribe and administer medicines safely. For example, escalating fridge temperatures that fell outside of parameters and monitoring medicines expiration dates. Systems to ensure the safety and efficacy of some clinical equipment were not in place. Records to show that the clinic room and equipment were regularly cleaned were not in place.
- Not all staff understood how to safeguard patients from abuse. Staff had training on how to recognise and report abuse, however they did not always know how to apply it.
- Clinical information was not always accessible, and the service did not maintain high quality clinical records. There was a mix of paper and electronic records. There were multiple places that physical health checks could be recorded, making them difficult to track. Staff did not always document risks to patients and themselves.
- The service did not develop individual care plans. They were not personalised, holistic or recovery oriented and did not include patient views.
- The hospitals audit programme had not been completed. Where audits had identified issues, it was not clear what action was being taken to address these. Complaint investigations did not record details of the investigation or outcome.
- Local leaders had not considered how recent high staff turnover and the appointment of significant new members to the multidisciplinary team should be supported to encourage the development and embedding of the 'right' culture across the hospital

However:

- Most staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They supported patients to understand and manage their care, treatment or condition.

# Summary of findings

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. Wards had a good track record on safety.
- Staff planned and managed discharge well. As a result, discharge was rarely delayed for other than clinical reasons.
- Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Forensic inpatient or secure wards** | Requires Improvement  | Our rating of this service went down. We rated it as requires improvement. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Battersea Bridge House

We undertook this short notice announced comprehensive inspection of Battersea Bridge House as part of our ongoing monitoring and inspection of registered services.

Battersea Bridge House is a low secure independent hospital in South West London. It provides care and treatment to men aged 18 years and over with severe mental illness and additional complex behaviour. Battersea Bridge House is part of the Inmind Healthcare Group, an independent provider of mental health and social care services.

The service has 22 beds and it provides services across three wards:

- Browning ward has 10 beds
- Blake ward has six beds
- Hardy ward has six beds

At the time of our inspection 21 of the 22 beds were occupied. All patients receiving care and treatment were detained under the Mental Health Act.

The service is registered to provide:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

The hospital director is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service.

Battersea Bridge House registered with the CQC in December 2010. There have been seven inspections. We last inspected Battersea Bridge House in February 2019 when we rated the service as 'good' overall, as well as 'good' in all domains.

**What people who use the service say**

Patients were positive about the majority of staff at the hospital. One patient commented staff were respectful and kind. All patients had one to one meetings with their nurses, but the regularity of these meetings varied.

All patients said they had authorised leave from the hospital. They were all aware of their rights under the Mental Health Act.

Three out of the four patients spoken with did not feel involved in their treatment plan. Only one patient had a copy of their care plans.

# Summary of this inspection

## How we carried out this inspection

The team that inspected this service consisted of two CQC inspectors, a CQC Mental Health Act reviewer, a CQC pharmacist specialist, an expert by experience and a specialist advisor who had experience working within low secure environments.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions therefore formed the framework for the areas we looked at during the inspection.

We used CQC's interim methodology for monitoring services during the COVID-19 pandemic including on site and remote interactions.

During the inspection visit, the inspection team:

- visited the service, observing the environment and how staff were caring for patients
- spoke with four patients who were using the service
- spoke with five carers of those using the service
- spoke with 15 members of staff including, the hospital director, clinical service manager, team leads, nurses, healthcare assistants, a mental health act administrator, the support service manager, an occupational therapist, a social worker and an independent mental health advocate
- attended a handover meeting and four patients ward round discussions
- reviewed nine patient care and treatment records. We also looked at specific documentation related to the mental health at on a further six records
- checked how medication was managed and stored, including reviewing 13 prescription charts
- reviewed three staff records
- reviewed information and documents relating to the operation and management of the service.

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

## Areas for improvement

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

**Action the service MUST take to improve**:

# Summary of this inspection

- The service must identify and mitigate the ligature risks and blind spots that exist across the whole hospital, including the seclusion room, in a consistent way to ensure the safety of patients. The service must also ensure that staff are aware of ligature anchor points and blind spots and the steps identified to manage them. **Regulation 12 (2)(a)(b)(c)(d)**
- The service must ensure patient's personal emergency evacuation plans are updated and easily available to staff in case of a fire evacuation. **Regulation 12(2)(a)(b)(d)**
- The service must ensure that safe staffing levels are maintained, using a recognised staffing tool. The service must also ensure that it has appropriate medical cover and recruits to other key MDT roles, for example psychology. **Regulation 18(1)**
- The service must ensure it complies with infection prevention and control policy, specifically in relation to staff wearing the recommended Personal Protective Equipment (PPE). **Regulation 12(2)(h)**
- The provider must ensure all medicines are in date and are stored at appropriate temperatures to ensure that they are effective. The provider must ensure all staff are trained and assessed as competent to complete medicines tasks. **Regulation 12(2)(f)(g)**
- The service must ensure staff complete mandatory training. **Regulation 18(2)(a)**
- The service must ensure all staff are aware of the safeguarding processes and their responsibilities. **Regulation 13(3)**
- The provider must ensure that appropriate systems and processes are in place to ensure the safety and quality of the service. The provider must also ensure that it completes its scheduled audit programme and acts upon the findings. **Regulation 17(1)(2)(a)(b)(f)**

**Action the service SHOULD take to improve:**

- The provider should ensure that records are available to show that the clinic room and its equipment are regularly cleaned.
- The provider should ensure that risks in relation to a mix of paper and electronic care and treatment records are addressed. The provider should also ensure that essential information, for example physical health checks and changes to individual patient risk is consistently recorded in the same place.
- The service should ensure care plans are individualised and involve the patient. The provider should also ensure that specialist forensic risk assessments (HCR20) are regularly reviewed and updated.
- The service should ensure it assesses the risks associated with unsupervised access to phones and the internet in line with the hospital risk assessment forms.
- The hospital should ensure systems are in place to ensure the safety and efficacy of clinical equipment, for example blood glucose monitoring kits.
- The service should ensure supervisors have up to date information related to their supervisees, for example, their current training records.
- The service should ensure that complaints investigations and their outcomes are appropriately recorded.
- The provider should ensure that appropriate measures are considered and actioned to support the development of the 'right' culture in the largely new MDT.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Forensic inpatient or secure wards | Inadequate | Requires Improvement | Requires Improvement | Good | Requires Improvement | Requires Improvement |
| Overall | Inadequate | Requires Improvement | Requires Improvement | Good | Requires Improvement | Requires Improvement |

Requires Improvement

# Forensic inpatient or secure wards

| | |
|---|---|
| Safe | Inadequate |
| Effective | Requires Improvement |
| Caring | Requires Improvement |
| Responsive | Good |
| Well-led | Requires Improvement |

## Are Forensic inpatient or secure wards safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

### Safe and clean care environments

Improvements were needed to ensure wards were always safe, for example how potential ligature risks were identified and managed. Works identified at a previous inspection in relation to mirrors to cover blind spots were in hand, but had not been completed. Work was needed to improve patient personal emergency evacuation plans. Some staff were not wearing face masks to protect patients from COVID-19. During the inspection we noted some outstanding maintenance issues in the seclusion room. Whilst clinic room equipment looked clean, there was no system in place to monitor how frequently they were cleaned.

All wards were clean and well furnished and fit for purpose.

### Safety of the ward layout

Staff did not regularly update thorough risk assessments of all ward areas. The hospital's ligature risk assessment was last updated in February 2020. The hospital director reported they reviewed sections of the assessment every few months, however the document as a whole had not been reviewed since February 2020. This meant there were ligature points still on the assessment that had been removed 12 months ago, such as a seclusion bed frame and wardrobe doors. The ligature assessment was incomplete, it did not contain areas of the ward such as the dining room, corridors and multifaith room, these rooms had therefore not been risk assessed for patient use. Of the rooms that had been risk assessed there were potential ligature points that were not included, for example, door hinges and open windows.

Three out of the six nursing staff we spoke with were not aware of any ligature points on the wards. These staff were therefore unaware of the mitigations of those identified risks.

Managers wrote mitigations for the risks on the ligature assessment, however these were short, such as 'operational management'. The ligature assessment had a 'protect or remain action plan', however, one of the mitigations stated 'patients zoning based on the patients risk'. Staff we spoke with were not aware what was meant by the term patient zoning. There was also no mitigation for risks that state 'remove and renew' whilst this work was waiting to be completed.

External window restrictors in patient bedrooms were on the ligature risk assessment. The mitigation for this risk was to keep the windows shut. However, most of the bedroom windows we saw in patient bed areas were open.

The daily or weekly checks on the ward did not include any checks on the ligature cutters available to staff. The ward ligature cutters were single use, staff we spoke to were not aware of this. We noted one ligature cutter appeared to have cardboard stuck on the blade. Staff were potentially using these inappropriately and the cutters may be blunt if they were needed in an emergency.

Whilst concerns were noted with the ligature risk assessment and staff's knowledge of ligature risks within the unit, the current patient profile somewhat mitigated these concerns. The current patients on the ward were assessed as being low risk in terms of self-harm and ligature incidents. In the 12 months between August 2020 and September 2021 there had been no reported incidents of self-harm.

Staff could not observe patients in all parts of the wards. All three wards had blind spots. Browning ward had mirrors installed in most areas, however they were awaiting one more mirror to be fitted. Both Hardy ward and Blake ward had no mirrors, despite blind spots. The hospital director reported mirrors had been ordered, however the wrong type was delivered and so could not be installed. The wards were awaiting new mirrors to be delivered and fitted, however there was no date for when these works would be carried out.

When we inspected the service in 2019 we noted similar concerns where there were potential risks presented by poor visibility in some areas of the wards. We also noted not all potential ligature anchor points were recorded on the ligature risk assessment. These concerns had not been addressed in this time and the risks we noted in 2019 still remain.

Staff had easy access to alarms and patients had easy access to nurse call systems. All bedrooms were fitted with alarms. Staff carried personal alarms on them at all times.

We looked into the ward's readiness to manage a potential fire within the hospital. Staff at the hospital were 46% compliant with their fire evacuation training. The ward kept a folder of patient's personal emergency evacuation plans, which detailed specific evacuation plans for each patient and would be used in an emergency event. However, seven patient forms were missing from this folder. Five of these forms were later found on the electronic system, but agency staff did not have access to this system. Two patient plans could not be found. Of the five forms we found on the electronic system, one was due to be reviewed in July 2021, but this had not been completed. Two did not have the scoring completed. One evacuation form stated the patient's English was poor and may not understand the language. There were no plans in place to address this concern, for example, there was no evacuation plan available in their language.

All forms had a code instead of the patient name. Regular staff stated they knew who the code belonged to. External staff would not know how to identify a patient by this code in an emergency. Some staff did not know what patients' personal emergency evacuation plans were, the reason for them or where they were kept. One member of staff did not see the need for these forms, whilst other staff did not know the folder had not been updated or who had oversight of these tasks.

The ward carried out a health and safety audit. This audit had a section on fire safety, however it did not include any checks on the patient evacuation forms. The service had however been completing fire evacuation drills and had a policy for this. The service last carried out a fire drill in September 2021. The evacuation took 11 minutes. The learning from this drill was for staff to be reminded of the procedure and for more regular drills to occur.

Requires Improvement

# Forensic inpatient or secure wards

## Maintenance, cleanliness and infection control

Ward areas were clean, generally well maintained, well furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Domestic staff cleaned communal ward areas daily. Patient bedrooms were cleaned weekly. Cleaning records were available for these areas.

Staff did not always follow infection control and COVID-19 policy. Whilst on site we noted not all staff were wearing face masks. Inmind's COVID-19 policy states 'All Inmind services would follow government advice on PPE to be worn. As a minimum all staff working in a site must wear a surgical face mask.'. This was raised with the hospital director, who stated all staff were required to wear masks, however some staff members said they were exempt. Staff had not had COVID-19 risk assessments, and the service had not kept a record of staff who were exempt from wearing masks. One staff commented they were not wearing a face mask anymore 'because the pandemic was over.'

In line with the service's COVID-19 policy, staff were required to complete COVID-19 lateral flow tests before every shift. This hospital ensured all staff had a negative test result before they entered the ward areas. The service also kept a log of whether staff had received COVID-19 vaccines.

The hospital completed an infection control audit in September 2021 which showed 97% compliance. This audit looked at hand hygiene, environment, kitchen area and disposal of waste.

## Seclusion room

The seclusion room was located on the ground floor of the hospital. Patients from other wards had to be escorted down a set of stairs and this was sometimes necessary to do under restraint. The ward was aware of this complication and had training available for staff in how to safely manage this manoeuvre.

The seclusion room was on a bedroom corridor. There was an issue of privacy both for the secluded patient and those patients in bedrooms next door and opposite. There had been no soundproofing of this room.

At the last inspection we found there were sharp corners on the bed and window ledge. These concerns had been fixed, but we found other concerns during this inspection. There were frames around the window and door which were potential ligature anchor points. The metal observation hatch in the bathroom area was coming loose and was a potential self-harm risk, as were large metal screws in the window ledge. There was also a plumbing hatch panel which was accessible to patients. A patient was recently able to access this panel and cause damage to the area. Following the patient incident the service added additional safety screws to make the hatch safe, however this hatch remained on the patient side of the room.

There was no clock in the seclusion room but there were screw in the wall for one to hang from. Staff were unaware of where the clock was. Staff stated they do not keep a clock in the room when it was not occupied.

## Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff had access to emergency equipment, including oxygen and a defibrillator, which were checked monthly.

We saw expired medicines available for use. Therefore, there was a risk that in an emergency, patients would receive medicines that were unsuitable for use. We highlighted this on the day of inspection and staff reported that they had taken action to rectify this.

Staff checked, maintained, and cleaned equipment. Equipment looked clean. Staff reported they cleaned equipment after each use, however there were no cleaning records to confirm the cleaning of this equipment. This was discussed with the hospital director at the time of the inspection, who advised they would implement a system to address this. Cleaning records were kept for hospital communal areas, there were no records of when the clinical room was cleaned.

### Safe staffing

The service did not always have enough nursing and medical staff who knew the patients to keep them safe. Staff were not always up to date with their basic training to keep people safe from avoidable harm.

### Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. Some qualified nursing shifts were unfilled. The hospital did not use a recognised tool to establish safe staffing levels. On some wards at night, there were times when they were staffed by a single unregistered nurse.

At the time of the inspection the hospital had vacancies for two registered nurses and three unregistered nurses. These posts had all been recruited into, and once these staff members started the hospital would be at full capacity for nursing staff.

The service used agency staff, their own bank staff and staff working overtime to cover vacant shifts. Over the past six months the service used agency staff to cover 7.84% of shifts, bank staff were used to cover 16% of shits and overtime was used to cover 6.23% of shifts. In the last six months 11 shifts were not filled, which was 0.4% of all shifts in this time.

When the service used agency staff, managers requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The induction paperwork for bank and agency staff was the same as the paperwork for permanent staff. This included information on topics such as working times, restricted items, current infection control guidance and local policies and procedures.

Over the last six months the sickness rate for the hospital had been 15.6%. This sickness figure was made up of registered nurses and healthcare assistants. At the time of inspection, the service had members of staff off on long term sick.

The service had calculated the number of registered nurses and healthcare assistants required for each shift. However, they did not use a specific tool to support them in this. For a day shift the service allocated three registered nurses and six healthcare assistants. For a night shift the service allocated two registered nurses and four healthcare assistants. Staffing numbers were allocated to the hospital as a whole. The service did not set specific staffing levels for each ward.

With the current staffing establishment one ward did not have a registered nurse on the night shift. One nurse was always allocated to Browning ward, the other nurse would work between Blake ward and Hardy ward.

When we last inspected this service in 2019 they reported using a modified version of the ‘Safer Nursing Care Tool’ to calculate the number of staff required on each shift. Their staffing establishment at this time also included three

registered nurses on a night shift. The service had therefore reduced its use of registered nurses. Managers adjusted staffing levels according to the needs of the patients. Additional staffing could be booked if a patient required a higher level of observation or there were pre-booked activities which affected staffing, such as longer patient escorted day leave.

Patients had regular one to one sessions with their named nurse. All patients reported having one to one sessions, however patients reported the regularity of these meetings varied from weekly to once every two months.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. On some occasions, leave was delayed due to staff having other commitments, but it was rarely cancelled. The cancelling of patient leave was a reportable incident within the service, however the member of staff we spoke with was not aware of this process.

Patients and staff met together each morning to plan leave and activities for the day. A patient commented they cannot take leave if they do not attend the 9.15am planning meeting and plan it into the day. Staff reported it was beneficial to have all patient requests for leave at this meeting so they were able to adequately plan staffing to support leave throughout the rest of the day. Staff said if a patient was unable to attend this meeting, they would still try to support them to have their leave, however staffing levels may not allow it at the specific time they request.

Managers reported the service had enough staff on each shift to carry out any physical interventions safely. Whilst the hospital had numbers to carry out the physical intervention safety, this left the other wards with very low staffing numbers, for example one health care assistant on a ward. At the time of the inspection 52% of staff required to complete mandatory training on preventing and managing violence and aggression had done so.

One member of staff told us they felt there was not enough staff in an emergency. They said they were often left with one member of staff on the quieter wards which feels unsafe. When a staff member was alone on the ward they were advised by managers to remain in the nursing station. However, we saw occasions where a lone staff member was out in communal areas.

### Medical staff

The service did not have enough daytime and night time medical cover. The hospital had one consultant psychiatrist as its only provision of medical cover. They had a part time specialist associate on their staffing list, however they had been on long term sick and were unsure if they plan to return.

With the current arrangements the consultant psychiatrist was on call at all times, including out of hours. The consultant reported being able to attend the unit within 15 minutes in an emergency.

There were plans to link with another Inmind service to provide medical support in case of sickness or annual leave, however there was no formal arrangement in place.

### Mandatory training

Staff were not up to date with their mandatory training.

Requires Improvement

# Forensic inpatient or secure wards

The service provided 24 training courses that were mandatory for all or some members of staff. These included health and safety, infection control, safeguarding adults and children, and immediate life support. Overall, staff in this service had undertaken 76.49% of the training that the hospital had set as mandatory. The hospital had an overall training target of 80%.

Compliance with eleven mandatory courses were below 80%. These included Mental Health Act awareness training at 26% compliance; fire evacuation training at 46% compliance, breakaway training at 48%; basic life support at 50% and medication awareness training at 61% compliance.

Some of the face to face training compliance scores had dropped due to the pandemic and the inability to hold face to face training. However, there were also outstanding courses which could have been completed online.

Mangers were aware of this concern and had discussed staff training figures at their most recent governance meeting. The service had organised training in basic life support and physical intervention training for later in the year. They had also been thinking about different strategies to enhance compliance figures, such as laptops being made available for training and setting aside specific dates for staff to primarily focus on completing their training.

## Assessing and managing risk to patients and staff

Specialist risk assessments for patients receiving care and treatment in forensic settings were not being regularly updated. Patients were able to access the internet unsupervised, but this had not been subject to individual risk assessment.

Individual patient risk was regularly reviewed and updated, but improvements were needed to ensure consistency in how these risks and their review were recorded. Staff did however follow best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

## Assessment of patient risk

We reviewed nine patient records. All records contained a formal historical risk management

framework that was used across forensic mental health services in England. This framework provided a detailed risk history of each patient. However, these records were not being updated. The ward psychologist was the lead clinician responsible for updating these forms. As there was no psychologist in post these risk assessments were not being updated.

We did not see any evidence of staff documenting any current or ongoing risk in any of the nine records. Staff reported they were recording risk on nursing handover sheets, however we found evidence of these handover forms not being completed in full. For example, the night shift not completing part of the handover sheet, risk sections not being updated, and patient updates not being recorded.

## Management of patient risk

Staff knew about any risks to each patient. Patient risk was discussed in handover meetings which was attended by all staff of shift.

Requires Improvement

# Forensic inpatient or secure wards

Staff reviewed patients risks at daily multi-disciplinary team (MDT) meetings, at fortnightly ward rounds and at six-monthly CPA meetings. At daily MDT meetings, staff allocated patients a risk rating of red, amber or green. These ratings were displayed, along with other key patient information, on a white board in the staff meeting room. During the inspection, three patients had a risk rating of red, nine had a risk rating of amber and nine had a risk rating of green.

Staff followed policies and procedures for the use of observation and for searching patients or their bedrooms. Searches were carried out in line with the patient's current risk rating, for example, a patient whose risk rating was red would be searched every time they came back from leave whereas a patient with a green risk rating would provide verbal feedback on their return from leave.

The service set the observation levels for patients according to the risk the patient presented. During the inspection, 13 patients were on standard observations. This involved staff checking where the patient was every hour. Five patients were on enhanced observations. This involved staff checking the patient every 15 minutes. Three patients were on continuous observations. This involved a member of staff being allocated to be with the patient at all times, for their safety or the safety of others. Patient's observations were reviewed daily at the morning MDT handover meetings, as well as at patient fortnightly ward rounds.

Staff usually applied blanket restrictions on patients' freedom only when justified. Blanket restrictions were proportionate to the needs of maintaining security in a low secure environment. For example, the service did not permit patients to bring alcohol or sharp objects onto the premises and doors to leave the building were locked at all times. The service only placed enhanced restrictions on patients if there was a specific need to do so.

During the pandemic the ward lifted the restrictions on the use of technology, such as mobile phones, tablets and computers. Patients were therefore able to use these devices in their bedroom. The service reported all patients should have had individual risk assessments for the use of electronic devices, however we did not see evidence of this form within the patient records.

Staff adhered to best practice in implementing a smoke-free policy. The service provided a smoke-free environment. Patients were offered nicotine replacement therapies including patches and gum.

## Use of restrictive interventions

Levels of restrictive interventions were low. There had been six incidents of restraint in the last 12 months. Staff participated in the provider's restrictive interventions reduction programme. This programme involved regularly reviewing a patient's risk rating and associated restrictions on areas such as a patient's leave and their observation levels. The service had seen a 60% reduction in the use of restraint in 2021 compared to 2019.

Staff made attempts to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Whenever restraint was used attempts were made to do this in a place that was not personal to the patient. This was so they do not associate rooms such as their private bed space with episodes of seclusion and restraint.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. There had been no use of intramuscular rapid tranquilisation in the last 12 months.

Requires Improvement

# Forensic inpatient or secure wards

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. In the last 12 months there had been three episodes of seclusion. All three patients had been from Browning ward. Records for episodes of seclusion were clear, showing reasons for seclusion and dates and times of commencement and termination. The records also stated when the responsible clinician and nurse manager were informed.

There was a seclusion care plan that detailed risks, what needed to happen for seclusion to end, food and fluid plans, removed items and whether families were to be informed.

Reviews for the latest seclusion were fully compliant with chapter 26 of the Mental Health Act Code of Practice. Medical and MDT reviews had taken place quickly even though it was the weekend. Nursing two-hourly reviews had all taken place and monitoring observations every 15 minutes were recorded. The patient was left alone while asleep. However, for one of the other records of seclusion, it was not clear if an MDT review had been done in a timely manner or if medical reviews had been carried out at the intervals expected.

## Safeguarding

Not all staff understood how to protect patients from abuse. Whilst staff had training on how to recognise and report abuse, they did not always know how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Eighty-four per cent of staff had completed a combined course in children and adult safeguarding.

Staff reported being aware of safeguarding processes and they would all raise any concerns with the clinical lead. However, staff were not aware of how to raise concerns when senior staff were not available, for example in the evenings or weekends. One staff member said if a safeguarding incident occurred at the weekend they would wait until Monday to inform senior staff as opposed to raise the concerns themselves. The staff member said there was a form to fill out for the local authority but had never used it and would not know where to find it.

There had been two reported safeguarding incidents in the last 12 months. One was an incident where a staff member was dismissed following being inappropriate with a patient and another where a patient was being financially abused by a stranger they had met online. Staff however mentioned an incident where two patients were fighting with each other and had to be placed on one to one observations a couple of days before the inspection. This was not reported as an incident or safeguarding concern.

The hospital's social worker was the primary person who liaised with local authority and the patient's community teams.

Staff followed clear procedures to keep children visiting the ward safe. There was a room in the reception areas which can be used by children accompanied by an adult. This room needed to be booked in advance.

## Staff access to essential information

A mixture of paper and electronic records were used and this had been identified as a risk by the hospital. Clinical information was not always accessible, and the service did not maintain high quality clinical records.

The service used both paper and electronic notes. Documentation such as handover notes and CPA documentation were being recorded electronically. Daily notes and updates to care plans were being handwritten. Onsite records were difficult to navigate. There were multiple forms to record the same pieces of information. For example, physical health was recorded in paper notes, a specific physical observations chart and the electronic system.

All staff said if they were unable to find a certain piece of information, they would approach the senior staff for guidance. Only one staff member reported potential difficulties with the records. They felt with paper records there were concerns information can go missing.

We found some handwritten staff entries that were not signed. For example, staff wrote comments on care plans in various places without signing it or using the designated review space to review the plan.

As these were paper records, the notes were only kept in paper files for up to 30 days. The service kept three to six months of records onsite. Notes older than six months were stored centrally with Inmind. This could mean essential information such as risks, care planning and personal information was not carried over or easily available for review.

The service carried out an audit on its record keeping in November 2021. This showed poor compliance with record keeping. The audit looked at eight patient records. The audit showed a percentage of compliance for each record. Those figures were 13% compliant, 45% compliant, 45% compliant, 48% compliant, 54% compliant, 60% compliant, 65% compliant and 76% complaint. There were no specific plans included in this audit, it only said 'to be actioned'. This plan did not include any detail, such as to who will action it and by what date.

Records were stored in the nursing office. All patient files had coded names ensuring only staff members knew which file belonged to which patient. We saw an instance of a nurse leaving a patient sat in the doorway of the nursing office when they left to tend to another issue. This could have compromised the confidentiality of those records.

Managers had identified potential risks in how the service used and managed paper records and had added this to the local risk register. This issue had been raised with Inmind, and there were some discussions around moving to fully electronic records.

### Medicines management

Staff did not always follow systems and processes to prescribe and administer medicines safely. Some medicines administration records had gaps in them. When a doctor prescribed medicines remotely, out of hours, an appropriate audit trail was not always in place. Less than 75% of staff had completed mandatory medicines training. Staff did not always store and manage all medicines safely. Improvements were needed to ensure that medicines were stored at the correct temperature. Improvements to systems were needed to ensure that medicines were not used when they had expired. Improvements were also needed with the administration of PRN 'as required' medicines.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance

Staff used prescription charts to record which medicines were prescribed and administered. In most cases, staff could access a photograph of each patient to assist in identifying them.

Requires Improvement

# Forensic inpatient or secure wards

The pharmacist screened prescription charts weekly to ensure that they were clinically sound and legally valid. Nurses administered medicines and signed prescription charts to prove that they were given as intended. However, we saw a gap on a prescription chart and were unable to establish if the dose was missed or whether it was given and not signed.

We saw that a doctor had given permission via email for a medicine to be given out of hours. However, we did not see any administration records for this medicine. In addition, we did not see a valid prescription written at the next available opportunity. This meant that we were unable to ascertain if the medicine had been given appropriately or not.

At the time of this inspection, 61.29% of staff had been trained to provide medicines support. Medicines training was completed every three years. This means there was a risk patients were being supported with their medicines by staff that had not received medicines training.

During this inspection, there was a period of time where the nurse with the medication key left the ward. The nurse we spoke to did not know where the nurse with the keys was so had to look for them on other units. If an incident requiring a medicine had occurred, patients could have come to harm by having to wait for staff to locate the medicines key.

Staff held weekly multidisciplinary team meetings where medicines were reviewed. A pharmacist attended this meeting and gave clinical input. The doctor and the pharmacist worked together to optimise the use of medicines. Patients were able to speak to staff about their medicines if they had any concerns. Staff ordered medicines, which were dispensed and delivered by a pharmacy service. However, systems for managing the ordering of medicines were not robust. As a result, people had missed doses of their medicines. For example, the stock item lactulose had run out with no plans identified to reorder this medication. A patient was also not given their prescribed medicated cream even though the medication had been delivered by the pharmacy.

Medicines were stored securely in locked clinical areas, but we identified concerns with the way that medicines were being managed. For example, staff recorded out of range room and fridge temperatures in areas where medicines were stored. The medicines audit completed by the pharmacist also identified an issue with temperature monitoring. However, the issue continued to persist, and it was not clear if staff had escalated the concern appropriately. When we inspected the service in 2019 we had noted similar concerns where staff were recording out of range temperatures but not escalating the findings to managers. This concern had therefore not been addressed with staff.

During this inspection, we saw a vial of insulin but could not tell how long it had been opened for. This meant that there was a risk that a patient had received a medicine that had already expired. The provider was unable to provide assurance that the blood glucose testing kits were suitable for use. This meant that there was a small risk that the blood glucose readings for patients may not have been accurate. Adrenaline pre-filled pens were stored in a clinical office to make them accessible in an emergency. However, it was difficult to access it, and when we did, we saw that one of the pens had expired.

During this inspection we looked at prescription charts for 13 people. All paperwork relating to medicines were stored securely in locked clinic rooms or in offices accessible only to staff.

Prescription charts were stored alongside Mental Health Act documents, which meant that staff could access them at the point of administration.

Staff did not always record where a topical preparation was supposed to be applied. This meant that there was a risk that patients would not get their medicines as intended.

Requires Improvement

# Forensic inpatient or secure wards

Medicines used 'when required' were not always managed appropriately. This was despite being identified as an area for improvement during the ward's medicines audit. For example, there was no protocol for the use of Loperamide as an 'as required' medication. The protocol dose for 'as required' ibuprofen was 200mg, but the prescription charts stated the dosage to be given was 200mg-400mg.

Staff conducted medicines reconciliation (the process of accurately listing all the medicines a patient is taking) on admission. The medicines list on the admission paperwork was cross checked with the physical stock of medicines. If there were any discrepancies, staff acted to clarify the correct medicines.

During this inspection we saw a different preparation being used compared to what had been prescribed. We pointed this out to staff and advised them to seek advice.

Staff had systems in place to manage medicines safety alerts and ensure that any actions required were taken.

Staff undertook medicines audits which highlighted areas for improvement. However, there was an acknowledgement that work was ongoing to embed good medicines practices.

We did not see any use of intramuscular rapid tranquilisation medicines. We saw minimal use of oral 'when required' medicines for the management of agitation or aggression.

When patients were admitted, an attempt was made to take baseline blood and electrocardiogram (ECG) readings. Monitoring was attempted periodically in line with NICE guidance, however, patients often refused to engage with this.

We saw that systems were in place to ensure that physical health checks were completed for people taking medicines that required additional monitoring. For example, Clozapine and Lithium. The pharmacy service had a specific Clozapine team that worked with the ward pharmacist and the ward staff if there were any concerns with the clozapine blood results.

## Track record on safety

The wards had a good track record on safety. The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Not all staff recognised incidents and reported them appropriately. Staff and patients were not always debriefed after incidents.

The service had one serious incident in the last 12 months. The ward team carried out an initial investigation. Following an inquest, a further review of the incident was taking place at corporate level. Some changes had been made as a result of learning from this incident.

## Reporting incidents and learning from when things go wrong

The hospital had an electronic system for recording incidents. All staff had access to this system and all staff were able to report incidents. However not all staff were able to easily navigate this system, for example, to be able to search for a specific incident using the incident number.

Requires Improvement

# Forensic inpatient or secure wards

In the 12 months between August 2020 and September 2021 there were 129 incidents. Of those incidents, 89 were on Browning ward, 12 were on Blake ward, 19 were on Hardy ward and nine were on non-ward areas.

Most staff reported they knew what incidents to report and how to report them. However, staff did not always raise concerns and report incidents and near misses in line with hospital policy. For example, staff mentioned an incident where two patients were fighting with each other and had to be placed on one to one observations. This had not been reported as an incident. We also found an incident in the notes involving a verbally aggressive patient. The staff emergency alarm was pulled twice, however this had not been reported via the incident system.

The service did not have any never events on any of the wards.

Staff understood the duty of candour. They were open and transparent when things went wrong. Training on duty of candour was mandatory, 89% of staff had completed this training.

Managers did not debrief staff after incidents. The staff we spoke to were not aware of any debriefs with staff or patients following an incident. Within the incident report there was a section for comments following a debrief. We looked at seven incident reports and none of these sections were completed.

Feedback and learning from incidents was recorded in the hospital's commissioner reports and governance reports. These reports were shared with staff. Managers reported learning was discussed in team meetings.

There was evidence that changes had been made as a result of learning from incidents. For example, aerosol cans were made a restricted item after inappropriate use by a patient and there was learning for staff to have simulation training on medical emergencies following a patient death. However, of the seven incident forms reviewed, five did not have any learning or action documented.

Managers shared learning with their staff about incidents that happened elsewhere. Managers shared learning from recent incidents within their partnerships, for example, there was a recent concern regarding spotlight fittings in the ceiling being used as a potential ligature point at another unit within the partnership.

## Are Forensic inpatient or secure wards effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

### Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission.

However, the service did not develop individual care plans which were reviewed regularly and included the patient. Care plans did not reflect patients' assessed needs, and were not personalised, holistic or recovery oriented. They did not include specific safety and security arrangements or a positive behavioural support plan. Physical health checks were not consistently recorded and it was unclear what checks had taken place and what, if any, follow up actions were needed.

Requires Improvement

# Forensic inpatient or secure wards

We looked at nine patient records. The hospitals archive policy meant that paper records were only kept on the ward for 30 days. This meant that for seven patients, a copy of their initial assessment was not available on the ward. For two patients, we did see that their comprehensive assessment on admission was still available in their paper care and treatment records.

All patient records contained a front sheet with heading for information such as physical health baseline observations, however these were not always completed in full. It was therefore unclear if all patients had their physical health assessed soon after admission. We also found examples where concerns were found during routine physical observations, such as high blood pressure, but it was unclear what plans were in place to follow this up. There were multiple places physical health checks and observations were being recorded, for example, EMDS, NEWS, progress notes and a paper form.

Patient's had numerous care plans in their records. One patient had 17 care plans. They often contained repeating themes, for example, a patient had two similar COVID-19 plans. Another patient had two diabetes care plans, but neither involved the patient's individual treatment or management plan. The care plans we saw were not individualised. Each patient on the ward had the same generic care plans.

Care plans were signed to say they were reviewed; however staff did not review the individual interventions. Most review updates were very short, such as saying 'continue'. There was no patient involvement documented in the care plans.

The hospital was not recording if a patient had refused certain interventions, such as, being involved in care planning. It was therefore unclear if patients had refused involvement or staff were not asking patients to be involved.

### Best practice in treatment and care

Whilst staff provided care and treatment suitable for the patients in the service, an ongoing vacant psychology post impacted upon the provision of best practice treatment for some patients. Staff were not consistently using recognised rating scales to assess and record severity and outcomes.

Whilst the hospital had developed a clinical audit programme, staffing shortages had impacted on the completion of this. Patients were supported to live healthier lives.

The hospital had one consultant who provided medical support and treatment. The occupational therapist provided a range of groups such as walking groups and cooking groups. These treatments and therapies were in line with good practice recommendations provided by NICE guidance. However, the ward did not have a psychologist. This meant the patients were not able to access individual psychological therapy, group therapy or family interventions. Many of the patients at the hospital had a psychosis related diagnosis. NICE guidance recommends psychological intervention as first line treatment for this patient group.

Staff made sure patients had access to physical health care, including specialists as required. For example, patients had been supported to attend the dentist and chiropodist.

When there were physical health concerns noted, patients would be referred to a GP to follow up.

The hospital's clinical lead nurse was duel trained in mental health and adult nursing. They therefore took the lead on physical health monitoring within the hospital. They had a meeting with a GP every month to discuss any patient concern and to get advice on patient care.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. If there were concerns, staff referred patient to dietitians through the patients GP.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The hospital had gym equipment which patients were able to use with staff supervision. The activities on the ward included two walking groups and a boxing class once a week for physical exercise. Nicotine replacement therapy was also offered in line with promoting healthier lives.

Staff did not routinely use recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The hospital reported using Health of the Nation Outcome Scales (HoNOS) to measure the health and social functioning of people with severe mental illness. Of the six HoNOS we reviewed only two had been completed and in date. Three were out of date and one had not been completed.

Staff used technology to support patients. The hospital used a blood monitoring service where they could see clozapine blood results for their patients when they became available. This system was able to show clozapine levels over time in a graph for easy interpretation.

The service had a programme of audits in line with Inmind's schedule, however these had not always been completed. For example, the restrictive practice audit had not been completed. Staff reported this was because a psychologist usually completes this audit and there was no psychologist in post. The high dose medication audit had also not been completed, again due to having no regular medical cover.

However, the service had completed some audits within the last 12 months, such as, environment audit, care records audit, health and safety audit, cleanliness audit and an infection prevention control audit.

Managers did not always use results from audits to make improvements. The recent case records audit showed poor compliance with record keeping, however there was no detailed plan identified to address these concerns. However, we did see action from an infection control audit which found staff were not adhering to being bare below the elbow in line with policy. The service had the action to resend the uniform guidance to all staff.

### Skilled staff to deliver care

Ongoing vacancies for a psychologist and speciality doctor meant that the team did not have access to the full range of specialists required to meet the needs of patients on the wards. Improvements were needed to ensure that line managers were able to access up to date training information for their supervisees.

Managers provided an induction programme for new staff. With the exception of the occupational therapist, staff received regular clinical supervision.

The service had a vacancy for a ward psychologist. The service was finding it difficult to fill the post. The hospital director reported they would liaise with commissioners to discuss action plans for this post. The service was therefore unable to provide psychological therapy for patients at the time of the inspection. The speciality doctor was on long term sick and it was unclear whether they would return to their post. No cover arrangements had been made.

Over the last 12 months, 17 staff members had left the service. This gave the hospital a turnover percentage of 40.96% over the last year. Over the last year, key members of the MDT had left, for example, the consultant psychiatrist, social worker, psychologist and occupational therapist.

Requires Improvement

# Forensic inpatient or secure wards

The service employed a consultant forensic psychiatrist, an occupational therapist, an assistant activity coordinator, a social worker, a clinical service lead, a hospital director, nurses and support workers.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Staff at the hospital had experience of working in forensic mental health settings.

Managers gave each new member of staff a full induction to the service before they started work. The induction included key information such as emergency contact details, incident reporting and fire procedures. The service had an induction checklist to ensure that all new staff were aware of key information. However, the induction and checklist did not contain information on ligature points and blind spots. The service was made aware of this whilst on inspection and they have since updated the checklist to include a review of significant ligature points, where ligature cutters were located and blind spots on the ward.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Over the last 12 months compliance with the hospital requirements for supervision ranged from the lowest figure of 74% in September 2021 to the highest figure of 92% in July 2021. The service documented the reason this was not carried out for a particular staff member, for example, annual leave or long-term sick.

We reviewed four supervision records, three of those records stated there were no outstanding training needs, when all three staff had outstanding training. The other staff had a generic plan 'to ensure training is up to date' with no information on what was outstanding and the timeframe for the training to be completed by. Supervisors were not aware of the training needs for their supervisees. Emails were sent to senior staff with training compliance updates, however ward nurses were also supervisors and did not have access to this information.

The service's occupational therapist had been in post since September 2021 and had not been able to access professional supervision as there was no other occupational therapist within the service. They had planned to find external support. They have however had regular managerial supervision within the hospital.

Managers supported staff to develop through yearly, constructive appraisals of their work. Over the last 12 months 83% of staff had an appraisal. Appraisals included discussions about employee's main duties, their overall performance, training and development and their future goals.

Staff we interviewed were unable to identify any specialist training they received as part of their role. Managers spoke of new roles being developed to support the pre discharge ward patients. This would involve further training in food hygiene and being able to supervise patients taking their own medication.

Managers recognised poor performance, they could identify the reasons and dealt with these. In the last 12 months two staff had been dismissed from the service. The service had followed their human resources policy when managing staff performance.

### Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. The ward teams had effective working relationships with relevant services outside the organisation and engaged with them.

Requires Improvement

# Forensic inpatient or secure wards

Monthly team meetings and specialist nurse meetings were not happening regularly and did not have a clear structure for what should be covered.

The ward teams had effective working relationships, including good handovers. Nursing staff and support workers held handover meetings twice a day at the start of each shift. The multidisciplinary team held a daily handover to review each patient and respond to any changes in each patient's presentation. Handover notes were accessible to staff, however, they were not always completed in full by nursing staff.

The MDT also met to discuss each patient in detail every two weeks at patient ward rounds.

The service had a monthly team meeting, as well as a monthly registered nurses meeting. Minutes were kept for both meetings. The monthly team meeting did not have an agenda. It was a space for staff to speak about any concerns. Whilst these were meant to be monthly these meetings were happening less frequently. The last four meetings were 8 September 2020, 23 August 2020, 19 May 2021 and 24 February 2021.

The registered nurses meeting ensured they discussed medicines management, however there was then no further agenda. It was again a space for staff to discuss any concerns. These meetings were also happening less frequently. The last four meetings were 11 August 2021, 04 May 2021, 31 March 2021 and 22 February 2021.

The hospital had effective working relationships with teams outside the organisation. The service worked closely with its Commissioners. The service was part of the South London Partnership. Through this they were linked with other similar services in the surrounding boroughs for learning and development. For example, the hospital director visited a forensic seclusion room at a local NHS hospital and met with staff to discuss ways for their service to develop.

The clinical lead met with an external GP monthly where they discussed any physical health concerns for patients in the hospital.

The occupational therapist had organised for external services to provide groups within the hospital, for example a boxing group and a music group. They also had links with volunteering services. One of their patients was part of this group and attended their external group activities.

When patients were approaching discharge, the service worked closely with care co-ordinators, care commissioners and staff at the accommodation where patients were planning to move to. The hospital social worker was the lead for managing discharges and liaising with community teams.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff did not keep up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice. Training compliance figures for this mandatory training was 26%. The hospital director reported they were looking for another provider to offer this training, however they did not have a plan in place to address this.

Requires Improvement

# Forensic inpatient or secure wards

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. The service had a Mental Health Administrator and the corporate Mental Health Act manager based within the hospital, who were both available to support staff during the week.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. These policies were under review at the time of our inspection. The policies were available on the hospital's shared drive for all staff to access.

Patients had easy access to information about independent mental health advocacy, there were posters with the advocacy details on all three wards. However, patients who lacked capacity were not automatically referred to the service. An advocate attended the hospital every two weeks who approached patients explaining their role. In addition, the advocate was able to attend specific meetings with patients if requested.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly each time.

All of the six patient records we checked had forms recording they had been informed of their status and rights. Four of the six records we checked had last been recorded on 29 June 2021. However, the hospital's expected standard was that these should be reviewed with the patient at least every two months.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. The service had a local form for section 17 leave. It included information on the type of leave, any conditions, operational dates and the review date. It was signed by the nurse who informed the patient of their leave requirements and it was then signed by the patient. Where there was a risk of a patient absconding, the leave was usually escorted.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. All six records were in order, with original detention paperwork available to view.

Care plans did not include information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. None of the records we reviewed specifically mentioned Section 117 aftercare. We saw evidence in one record of a discharge planning meeting taking place, the details of this discharge planning meeting was within the patients ward round minutes. All patients had a generic care plan called 'least restrictive' care plan. These plans were the same for all patients. The care plans mentioned patients leaving the unit for activities, however these were not always completed in full or did not have a name on the form, making it difficult to follow specific patient discharge plans.

In relation to a patient's detention under the Mental Health Act and their capacity to consent to treatment there were some concerns noted about the capacity and consent forms completed by a previous responsible clinician. Three out of the six records reviewed had capacity and consent records that were contradictory. For example, the same assessment document said the patient lacked capacity but agreed to the treatment or that they consented to the treatment but didn't understand it. We raised this with the service and were told the board were aware of these concerns.

Requires Improvement

# Forensic inpatient or secure wards

Managers and staff did not ensure the service applied the Mental Health Act correctly as they had not completed audits to assess compliance with standards. However, the records did appear to be well maintained by Mental Health Act staff.

### Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They were aware of the provider's policy on the Mental Capacity Act 2005.

Staff received training in the Mental Capacity Act. The service had a compliance figure of 67% for this mandatory training.

The hospital had a policy on Mental Capacity Act and deprivation of liberty safeguards, which was available on the hospital's shared drive.

If staff had worries about a patient's capacity they would raise the concerns with their managers.

Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

## Are Forensic inpatient or secure wards caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

### Kindness, privacy, dignity, respect, compassion and support

Most staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Most staff were discreet, respectful, and responsive when caring for patients. Staff were observed to be responsive and caring especially when they were responding to patient requests.

Three out of the four patients we spoke to reported most staff were helpful and provided emotional support when needed.

Two of the patients we spoke to specifically mentioned a member of staff who had been inappropriate in their behaviours towards them. This was raised with the service and they were conducting an investigation to look into this.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, staff supported patients to engage in community activities such as a community café through a voluntary agency.

Requires Improvement

# Forensic inpatient or secure wards

Staff did not always follow policy to keep patient information confidential, for example, leaving the nursing office door open. In some cases we saw efforts to protect patient confidentiality, however we saw information with no patient names on them, this made it unclear to see who the information belonged to.

## Involvement in care

Staff did not involve patients in care planning or risk assessment. They sought patient feedback on the quality of care provided. Staff ensured that patients had easy access to independent advocates.

## Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. The ward had an induction pack which included some information on the ward, the staff and some of the hospital processes.

Staff did not involve patients in their care planning and risk assessments. Three of the four patients we spoke to said they were not involved in their care and treatment plans. Generic templates were used for patient care planning. These care plans were not written from the perspective of the patients, they were not signed by the patients and there was no evidence a copy had been shared with the patient. Only one patient we spoke to had copies of their care plans.

Patients attend their ward rounds and CPA meetings where their care and treatment plans were discussed. Patient were able to meet with staff before these meetings to discuss their thoughts and expectations.

Staff did not always find ways to communicate with patients who had communication difficulties. For example, a care plan for a patient with learning disabilities stated they were 'a poor listener'. Staff had not made a plan to look into ways they could improve that patient's understanding. Easy read leaflets and forms were available on their hospital shared drives. These were not printed or displayed in patient areas.

Staff involved patients in decisions about the service, when appropriate. For example, patients had been involved in discussions around the changes to the ward layout. They discussed the proposed plans as a group as well as individually. Patients had a space to discuss their thoughts and concerns. However, patients had not been involved in areas such as recruitment processes or attending governance meetings.

Patients could give feedback on the service and their treatment. All patients knew to approach staff if they had any concerns with the service. The hospital had a planning meeting every morning and patient were able to raise any concerns with staff at these meetings. They also had a weekly community meeting chaired by the occupational therapist where patients could also raise concerns.

The service carried out annual patient surveys. Five patients responded to the most recent survey. Overall themes were patients felt respected, safe and staff responded positively toward them.

Staff made sure patients could access advocacy services. The Advocacy Project provided the hospital's advocacy services. An advocate attended the hospital every two weeks and was also contactable by phone. Staff rarely made referrals to the advocates. The advocate approached patients and informed them of the ways an advocate could support them.

All wards had an advocacy services poster with the contact details on it. However, one patient reported not knowing how to contact an advocate

Requires Improvement

# Forensic inpatient or secure wards

## Involvement of families and carers

Families and carers gave mixed feedback about being kept informed and involved in their loved ones care.

Most of the carers we spoke to described staff as being friendly and approachable. One carer however mentioned it was difficult to get to know staff members as the staff group changed frequently.

Staff supported, informed and involved families or carers. Four out of the five carers we spoke to said they felt involved in their relative's care. However, one carer said they had not been invited to any meetings and had not had any telephone call updates.

Two carers also specifically commented they felt more could be done to support their relative's physical health whilst they were on the ward, such as more involvement in physical activities.

The service did not routinely collect feedback from carers. The hospital's social worker was in the process of setting up a carers group.

## Are Forensic inpatient or secure wards responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

## Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

## Bed management

Bed occupancy within the service varied each month. In the six months between April 2021 and September 2021 bed occupancy varied from 83% to a highest figure of 93%.

During the inspection, there were 21 patients at the hospital, giving a bed occupancy rate of 95%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. These figures were monitored and reported to their commissioners every three months.

At the time of inspection, the service was commissioned by the North and South London partnerships, which meant that all patients were from the Greater London area.

When patients went on leave there was always a bed available when they returned. There were two patients on leave at the time of the inspection. Their rooms had been locked until their return to keep their valuables safe. The service did not admit new patients to beds allocated to patients who were on overnight leave.

Requires Improvement

# Forensic inpatient or secure wards

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. For example, when someone was progressing towards discharge they would be moved to the pre-discharge ward where there was more focus on enhancing activities of daily living, such as cooking and managing their own medication.

Staff did not move or discharge patients at night or very early in the morning. Discharge plans were made together with the patient, hospital clinical team and the new accommodation team.

The service maintained links with other secure hospitals. This meant that should a patient need treatment in a more intensive ward they could be readily assessed. For example, the service had recently transferred one patient to another hospital due to disruptive and violent behaviour caused by a deterioration in their mental health. The service transferred the patient to a medium secure unit in the same region.

## Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed.

Discharge was rarely delayed for other than clinical reasons. Within the last 12 months the discharge of one patient had been delayed. This was due to their place within a step down hospital no longer being available. The service was working with the community teams to find suitable options for their patient.

Staff planned for patients' discharge, including good liaison with the patient's community teams. The hospital's social worker led on this work. The service planned patients' discharges over a number of months. Usually this involved the patient visiting the proposed new accommodation for a number of days and having overnight leave to that accommodation before the full discharge.

## Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward mostly supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom with en-suite facilities, which they could personalise.

Patients had a secure place to store personal possessions. There were lockers in the patient's bedrooms, as well of personal lockers in the kitchen areas. However, one patient's bedroom locker was broken and therefore they were unable to store their items safely within their room.

Staff and patients had access to the full range of rooms and equipment to support treatment and care, for example, clinic rooms, lounges and space for activities. However, the ward areas were small. There was not always a private space to carry out interventions, for example staff were having one to one meetings with patients in communal areas such as the dining room. Each ward had a clinic room, due to the small size of these areas, physical observations were being carried out in patient bedrooms.

The service had a room near reception where patients could meet with visitors in private. This room needed to be booked in advance.

All patients had access to their mobile phones. They could therefore make phone calls in private areas such as their bedrooms.

The service had an outside space that patients could access. The garden area was locked and patients were supervised whilst using this area at specific times throughout the day.

Patients could make their own hot drinks and snacks and were not dependent on staff. All wards had a kitchen space for patients to use independently.

The service offered a variety of good quality food. The majority of patients reported no concerns with the food. However, one patient commented there were often no healthier options, such as brown rice. The food menus at this service were reviewed and amended by a nutritionist from Inmind.

### Patients' engagement with the wider community

Where appropriate, staff supported patients with activities outside the service, such as work, education and family relationships**.**

Staff made sure patients had access to opportunities for education and work, and supported patients in these areas. For example, one of their patients had been supported in applying for a mechanics course.

The hospital's occupational therapist was new in post. They reported being in the process of looking into options such as a local recovery college and open university to support their patients.

The service had links with voluntary services. They had one patient who attended the external walking groups and coffee groups provided by the voluntary service.

The hospital had external services coming into the hospital to support their patients, such as a boxing instructor and a music facilitator.

Staff helped patients to stay in contact with their families and carers. During the pandemic the hospital provided patients with laptops and tablets to allow them to have video calls with their family and friends. The hospital also authorised leave for patients to see their families and participate in activities with family members.

### Meeting the needs of all people who use the service

The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service made adjustments for disabled patients. The ward could usually be accessed using a lift, although the lift was not working at the time of the inspection. The service had installed facilities on the staircases to ensure any patients with impaired mobility could be evacuated safely.

There were inconsistencies in the information available to patients on the different wards. For example, only Hardy ward had information on how to make a complaint. Two of the wards had information on interpreting services. None of the wards had information on treatment or local services. However, all wards had information on how to contact the advocacy service. Staff advised that leaflets were available in other languages and in easy read formats on request.

Requires Improvement

# Forensic inpatient or secure wards

Two of the wards had information displayed on interpreters. The service reported having links with an interpreting service who had supported patients at ward rounds and CPAs, as well as nursing one to ones and discussions with carers.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. The service could provide Kosher, Halal and vegetarian meals.

The service ran groups such as newspaper groups. The activity coordinator would attempt to provide news articles from patient's different countries and cultures.

Staff ensured that patients had access to appropriate spiritual support. The service had a multi-faith room within the hospital for patient to use. Patient's had also been supported to have leave to attend Churches and Mosques.

## Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Improvements were needed to how the service recorded the outcome of complaints investigations.

Whilst some patients and carers said they did not know the official complaints route, they commented that they would feel comfortable raising any concerns with ward staff. Whilst information on how to make a complaint was not displayed on all wards, it was included in the patient induction booklet.

The service's complaints procedure stated they had five working days to send an acknowledgement the complaint had been received. They had 20 days to complete the investigation and send a full response to the person who raised the complaint.

The service assigned a senior member of staff to investigate each complaint.

The service had received four complaints in the last 12 months. All of these complaints had an initial acknowledgement letter. One had a full response documented after 20 days. Staff reported the outstanding three responses had all been resolved outside of the complaints process, however there was no documentation to show those outcomes.

The service had a minor complaints book where patients wrote lower level concerns such as a blocked sink or toilet. There were five entries in the book however there were no documented outcome for any of these minor complaints, so it was unclear if these issues had been resolved.

Managers reported learning from complaints was disused at the monthly governance meeting. These minutes were then emailed to staff. However, the staff we spoke with were not able to provide any examples of learning from complaints.

Requires Improvement

# Forensic inpatient or secure wards

## Are Forensic inpatient or secure wards well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

### Leadership

Leaders had the skills, knowledge and experience to perform their roles and were visible in the service and approachable for patients and staff.

Leaders had the skills, knowledge and experience to perform their roles. The hospital director, clinical lead and consultant forensic psychiatrist carried out the main leadership roles within the hospital. Each of these people had experience of working in similar services. The hospital director had extensive experience in mental health services and had managed other similar hospitals. A number of the leadership team were new to their roles. Further work was needed to identify clear leadership roles and accountabilities and to take forward developments in order to ensure improvements in the service.

Leaders spent time on the wards and were available for discussions when needed.

There were some opportunities becoming available for staff below team manager level. The hospital was in the process of developing senior support worker roles. These roles would include extra responsibilities, including taking the lead in certain clinical areas. They had requested expression of interests from their permanent staff and were awaiting responses. However, one staff member said they felt there was no development for their role in the hospital.

### Vision and strategy

The hospital director reported Inmind did not have any specified vision or values. They reported the corporate team had a meeting scheduled to address this in the near future.

Staff did not always feel they had the opportunity to contribute to discussions about the strategy for their service. For example, some staff said they did not have a voice to make a difference and there was no forum to provide feedback as the staff meetings were unstructured with no clear outcomes. However, other staff felt involved in the decisions of the service, for example one support worker had attended the governance meeting to discuss certain topics they had prior knowledge in.

### Culture

Recent significant changes to the multidisciplinary team, high staff turnover and mixed staff feedback indicates that not all staff felt respected, supported and valued and that work to ensure the development of the 'right' culture should be undertaken.

Staff could raise concerns without fear.

Requires Improvement

# Forensic inpatient or secure wards

Most staff felt respected, supported and valued. Staff commented they specifically felt the hospital director was supportive when approached. However, one staff member said they did not feel the service did all they could in terms of support when they were involved in an incident with a patient.

Over the last year, the service had been through a difficult period. A previous consultant psychiatrist had been suspended and dismissed from their post. MDT staff including a psychologist, psychology assistant, occupational therapist and social worker all left the service around the same time. The service therefore had a new MDT who were in the process of establishing themselves.

The was no work underway or planned to support the development of the 'right' culture within the new MDT. During the inspection, we observed an incident of inappropriate interactions between staff on the ward. This was highlighted to the hospital director at the time of the inspection.

We received mixed feedback from staff in relation to the service. Some staff felt positive and proud about working for the service. Other staff said that they felt their voice was not listened to. Some staff felt morale had been affected by recent high staff turnover.

Staff felt able to raise concerns without fear of retribution. Most staff knew about the whistle-blowing process. The service did not have a specific whistle-blowing policy, however the information was included in their freedom to speak up policy. The service had a freedom to speak up guardian at corporate level. However, staff on the ward were unable to recall who their freedom to speak up guardian was.

Managers dealt with poor staff performance when needed. The service had been pro-active in addressing poor performance through the disciplinary process.

Staff had yearly appraisals. Appraisals included conversations about career development and training needs. They discussed how staff could be supported to achieve those development goals.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The hospital was linked with an employee assistant programme which provided a 24-hour confidential support line.

## Governance

Our findings from the other key questions demonstrated that governance processes were not operated effectively at team level and that performance and risk were not managed well.

Whilst there was a clear framework of what must be discussed at governance meetings, these meetings were not happening regularly.

There was no clear structure or framework for team meetings and nurse meetings. Neither of these meetings were happening regularly.

The hospital did not have any specific local management meetings for team leads and clinical leads. There was no forum for these seniors to come together and share information and formulate the direction of travel as a leadership team. It was not always clear who was progressing or overseeing certain actions. For example, there were concerns from the last inspection which remain points of action, such as work around ligature points on the ward, record keeping and staff not escalating concerns such as the fridge temperatures.

Requires Improvement

# Forensic inpatient or secure wards

The hospitals governance systems had failed to identify or appropriately address a range of quality and safety issues including; the identification and management of ligatures; blind spots; personal evacuation plans; the wearing of face masks; low compliance rates with some mandatory training courses; the management of medicines and staffing. The hospitals governance systems had not ensured that actions identified at previous inspections for example, blind spots had been addressed. Where issues had been identified through audit, for example in patient care and treatment records, it was not clear what action was being taken, or who was leading on this.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. The unit had close links with their commissioners, the South London Partnership. The hospital director recently visited a ward within an NHS hospital to enhance the way their hospital managed seclusion. The hospital director also attended weekly meetings with the other hospital directors across Inmind where they discussed any concerns and shared learning.

## Management of risk, issues and performance

Staff maintained and had access to the risk register. Staff at ward level could escalate concerns when required. The risk register was stored on the shared drive which all staff had access to. The register was updated at the governance meetings and all staff were able to report concerns.

Staff concerns matched those on the risk register. For example, staff concerns were around staffing levels and the paper notes system.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. The service had a business continuity plan which covered a range of incidents and recovery plans. Plans included emergency contact details and a list of action staff should take in the event of an emergency.

## Information management

The service used systems to collect data from wards that were not over-burdensome for frontline staff. The ward collected information relating to performance, such as length of stay and delayed discharged. This collection of information did not impact the ward team.

Information such as how many hours of meaningful activity patient received used to be collected by the ward psychology assistant, however they are no longer in post and therefore this information was not being collected. Patient outcomes measures were not routinely carried out.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. The hospital recently updated their phone system to cordless phones. this allowed staff to be reachable even when not at their desk. Staff reported they had found this useful. Some staff had said the computer systems were slow when completing online training. Laptops had been therefore made available for staff to use.

The hospitals note system was mostly a paper system which can be difficult to maintain and navigate. Some documents such as the handover sheets, ward round notes, CPA documentation and some physical health observations were being completed and stored electronically.

Managers acknowledged some of the downfalls of paper records. This concern was on the hospital's risk register. They had concerns such as the misplacement of paper files or incorrectly labelled forms, which could lead to loss of information.

Concerns had been raised with Inmind. They were reportedly planning to trial an electronic system at one of their other hospitals, if this trial went well they would extend this electronic system to all of their locations.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. However, some staff who provide a supervisory role did not have all of the information they needed, such as training records of the staff they supervise.

Information was in an accessible format and was timely and accurate. Information was gathered and collated for governance meetings, both within the hospital and for their commissioners. This information was presented in a report style document.

Staff made notifications to external bodies as needed. The service submitted statutory notifications to CQC when required. The service notified the local authority of the safeguarding concerns found on the ward.

### Engagement

Staff and patients had access to up-to-date information about the work of the provider and the services they used. Staff were kept up to date thorough team meeting and emails. Patients were kept up to date through community meetings. Due to the small size of the hospital managers were able to meet with staff and patients regularly.

Carers had not been routinely kept up to date with information about the service. However, they were in the process of setting up a carers group where they would be able to provide updates on the service to those carers.

Patients and carers had opportunities to give feedback on the service they received. Patients completed a yearly survey on topics related to their experience of care at the hospital, however only five patients completed the last survey. Patients were also able to provide feedback in their ward round and CPA meetings on their care and treatment. Carers were able to provide feedback to staff and management as required, however this was not in a routine, structed format.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. For example, the hospital had made updates to their ward amenities based on patient feedback.

Patients were involved in decision-making about changes to the service. Patients were informed of the proposed changes to the ward layout in their community meetings. The hospital manager also spoke with patients individually to allow a space for questions and feedback. Patient's had an opportunity to discuss their thoughts and concerns, and these were listened to.

Patients and staff could meet with members of the hospital's senior leadership team to give feedback. The management team worked closely with patients and staff in an open and approachable manner. Members of the leadership team spoke with staff and patients each day.

### Learning, continuous improvement and innovation

Requires Improvement

# Forensic inpatient or secure wards

The service did not use any structured quality improvement model to improve and develop the service. However, they recently created a subgroup for their governance meeting to specifically look at quality improvement within the service.

Wards participated in accreditation schemes relevant to the service and learned from them. The service was a member of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services and received regular reviews.

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 |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The service did not ensure it was doing all that was reasonably practicable to mitigate any such risks to the health and safety of the service users.<br><br>The service did not ensure the proper and safe management of medicines.<br><br>The service did not assess the risk of infection to control the spread of infections. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Systems and processes were not established and did not operate effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Systems and processes were not established and operated effectively to ensure compliance with the requirements. |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

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|---|---|
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>The service did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet the service requirements. |