St Andrews Healthcare

St Andrews Healthcare - Birmingham

Quality 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 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

Overall rating for this service	Good
Long stay/forensic/secure services	Good

Summary of findings

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Summary of findings

Overall summary

St Andrew's Healthcare Birmingham is an independent hospital which provides medium and low secure support for people with mental health needs and or autistic spectrum conditions.

The hospital is registered to accommodate up to 128 people and is made up of eight wards.

There is one ward, Moor Green, which is for women only.

Staff in all wards were caring and compassionate. We saw that they worked positively with people and supported them well.

There were policies in place to make sure that patients were safe. We found that staff worked well together to meet people's needs and that they were able to respond to individual needs and preferences.

Staff said that they were supported by managers and senior managers, which helped them to feel valued.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires Improvement

We found that medicines were managed safely on the wards. However, we found that medicines in the pharmacy were not stored and disposed of safely.

There were enough staff to provide safe care. The number of staff was increased to meet people's needs and ensure their safety. However, we found in Speedwell ward that most staff did not take their breaks, which could impact on people's safety.

We found that systems were not in place in the kitchen used by the people in Northfield ward to ensure that food was safely stored.

The seclusion room in Northfield was not safe at the time of our inspection but was made safe following this. In Edgbaston ward the seclusion room intercom was not clear so that people using this were not able to hear staff and summon assistance if needed.

Staff had received safeguarding training and demonstrated that they knew how to protect people from harm.

Staff were trained in managing violence and aggression. We found that restraint was used safely and only as a last resort.

There were no ligature risks on the wards, which helped to ensure people's safety.

Are services effective?

Good

People were not consistently supported to participate in regular activities.

People's physical health needs were assessed and monitored to protect their health and wellbeing.

Staff received the training they needed to meet people's needs.

Staff worked well together to meet the needs of patients.

Systems were in place to ensure that the Mental Health Act was used effectively.

People's mental capacity was assessed.

Are services caring?

Good

Staff were caring and compassionate, and they were motivated to make sure that people were well supported.

All visits to people were supervised by staff which impacted on people's privacy.

Summary of findings

Patients were treated with dignity and respect.

Most people were involved in their care and treatment plans. However, some people in Speedwell were not always involved in this care as information was not provided in a format they could understand.

Are services responsive to people's needs?

Good

Staff worked with community teams to plan people's discharge from hospital.

All people were searched on return from leave regardless of their assessed risks.

Wards were generally comfortable. However some improvements could be made. We found that Speedwell ward was big, which did not always positively respond to the individual needs of people with autism.

The service met people's religious and gender-specific needs.

Staff had access to good interpreting services. This meant that people could communicate their needs effectively, and staff knew how to respond.

We found that concerns or complaints were dealt with and improvements made where needed.

Are services well-led?

Good

Staff were generally well supported by their managers and by the senior management. Staff in Speedwell ward were not supported to take their breaks. There were insufficient occupational therapy staff which led to some staff feeling unsupported.

People's personal information was not always kept confidential and handled appropriately.

Patients were listened to and, as a result, improvements made.

Staff had opportunities to develop their skills and knowledge.

Summary of findings

What we found about each of the main services at this location

Long stay/forensic/secure services

Good

St Andrew's Healthcare Birmingham is an independent hospital which provides medium and low secure support for people with mental health needs and / or autistic spectrum conditions. The hospital is registered to accommodate up to 128 people and is made up of eight wards. There is one ward, Moor Green, which is for women only.

Staff in all wards were caring and compassionate. We saw that they worked positively with people and supported them well.

There were policies in place to make sure that patients were safe. We found that staff worked well together to meet people's needs and that they were able to respond to individual needs and preferences.

Staff said that they were supported by managers and senior managers, which helped them to feel valued.

Summary of findings

What people who use the location say

People told us that they felt safe at the hospital.

Several people told us that their bedrooms were cleaned every day and that the ward was always clean. People told us they could personalise their bedrooms.

People told us that seclusion was not often used. They thought this was good as they had been in seclusion in other hospitals they had been in.

People told us that the staff were good and respected them.

People told us that sometimes they got bored as there were not enough staff to support them to do regular activities.

Some people told us they did not like the food. However, other people told us they enjoyed the food provided.

Several people told us that they had not agreed with their plans about controlling their weight.

People told us that all visits were supervised and could not always see why this was needed.

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that all staff follow safe medicine management policies.

The provider must ensure that all nursing staff are informed of the investigation outcomes following the reporting of medicine errors.

Action the provider SHOULD take to improve

The provider should ensure that all food in the hospital is stored safely.

The provider should ensure that all staff are able to take their breaks.

The provider should ensure that all seclusion rooms are safe for people to use.

The provider should ensure that more staff are trained to use the gym so they can safely support patients.

The provider should ensure that information about people's care and treatment is provided in a format that each person who uses the service can understand.

The provider should ensure that all wards are comfortable to promote the wellbeing of patients.

The provider should ensure that systems are in place to ensure that when the ward manager is absent action can still be taken to make improvements to benefit patients.

The provider should ensure that people who may not have capacity to make decisions are assessed as required to ensure that the appropriate safeguards are in place.

The current Independent Mental Health Advocacy (IMHA) service should be reviewed to ensure that all patients can access this service if they choose to.

The provider should review the size and layout of Speedwell ward.

It should be clear in people's records why some people had regular unescorted access in the community but could not go out in the garden when they wanted to.

The provider should review the policy of supervised visits for all patients.

Good practice

One person who used the service in Hawkesley ward was studying for a Master's degree. The hospital had supported the person to get a laptop, which helped them in their studies.

People in Northfield ward were supported to access community based college courses and work placements.

Each ward had at least one 'buddy'. This was a person who used the service and they showed people around the ward on admission which helped them to feel safe.

Patients were involved in recruiting new staff.

Summary of findings

Staff on wards at Birmingham showed a good knowledge of individual patients, individual risks concerning those people and how they were most effectively managed.

We saw good examples on wards in Birmingham of how individual patients were treated to help them, as part of their rehabilitation, into more community-based living.

St Andrews Healthcare - Birmingham

Detailed findings

Services we looked at:
Long stay/forensic/secure services.

Our inspection team

Our inspection team was led by:

Our inspection team was led by:

Chair: Stephen Firn CEO Oxleas NHS Foundation Trust

Team Leader: Nicholas Smith Head of Hospital Inspection CQC

The team included CQC inspectors and a variety of specialist and experts by experience.

The team that inspected this location were a CQC hospital inspection manager, two CQC inspectors, a consultant psychiatrist, occupational therapist, psychologist, nurse, two Mental Health Act Commissioners, CQC pharmacist inspector.

Background to St Andrews Healthcare - Birmingham

St Andrew's Healthcare is a charity providing specialist mental health care which was established 176 years ago. The Charity provides services for adolescents and young adults, women, men and elders, with 1000 inpatient beds. Additionally it provides community and in-reach services, private therapy services for GP-referred patients and medico-legal expertise.

There are eight long stay/forensic/secure wards on the site of St Andrews, Birmingham. They are purpose built facilities and provide inpatient mental health services for up to 128 adults aged 18 years and over.

Northfield ward is a low secure ward for up to 16 men. There were 12 patients on the day of our inspection.

Hawkesley ward is a medium secure ward for up to 15 men. There were 14 patients on the day of our inspection.

Speedwell ward is a low secure ward for up to 18 men who have an autistic spectrum condition. There were 17 patients on the day of our inspection.

Edgbaston ward is a medium secure ward for up to 15 men. There were 14 patients on the day of our inspection.

Hazelwell ward is a low secure ward for up to 16 men. There were 15 patients on the day of our inspection.

Hurst ward is a low secure ward for up to 16 men. There were 15 patients on the day of our inspection.

Lifford ward is a low secure ward for up to 16 men. There were 15 patients on the day of our inspection.

Detailed findings

Moor Green ward is a low secure ward for up to 16 women. There were 16 patients on the day of our inspection.

St Andrew's Birmingham has been inspected twice since registration. There were no compliance actions made at these inspections.

Why we carried out this inspection

We inspected this core service as part of our wave 2 pilot comprehensive mental health inspection programme.

St Andrew's has been selected as one of the second wave of organisations providing mental health services to be inspected under the CQC's revised inspection approach. The provider was included as the only independent health provider in the wave programme as its composition is similar to a NHS trust.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 9, 10 and 11 September 2014.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and social workers. We talked with patients. We observed how people were being cared for and talked with five carers and/or family members and reviewed care or treatment records of patients.. We met with 40 patients who shared their views and experiences of the core service.

Mental Health Act responsibilities

Information about the service

There are eight long stay/forensic/secure wards on the site of St Andrews, Birmingham. They are purpose built facilities and provide inpatient mental health services for up to 128 adults aged 18 years and over.

Summary of findings

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

We saw that people who were detained there under the Mental Health Act (MHA) had the appropriate documentation in place for consenting to their treatment including medicines. Where people had been prescribed treatment without their consent, because they did not have the mental capacity to do so, or had refused to, we saw that a second opinion appointed doctor (SOAD) had seen them and stated that it was appropriate for treatment to be given.

Records we sampled showed that people's forms for when they had section 17 leave from the ward had been completed appropriately. These included a risk assessment completed before the person went on leave to ensure their safety and wellbeing.

We saw that the checklist that staff used for informing people of their rights had two of these rights missing. These were the right to see the MHA Code of Practice and access to an Independent Mental Health Advocate (IMHA). This could mean that people were not aware of these. We found that few patients accessed the IMHA.

Records we sampled showed that staff had attempted to explain to people their rights under the MHA. However, six records we sampled showed that the person had refused this but staff had recorded that the person had understood their rights. This potentially meant that staff might not make further attempts to explain these to ensure that people were aware of their rights. Another record stated that the person did not understand their rights. There was no evidence to show that further attempts were made to explain these to the person.

We saw that people had used their right to an appeal of their detention under the MHA.

Mental Health Act responsibilities

We found that the Mental Health Act Administrator regularly scrutinised the MHA detention papers to ensure that people were lawfully detained there under the MHA.

Good

Long stay/forensic/secure services

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

Information about the service

There are eight long stay/forensic/secure wards on the site of St Andrews, Birmingham. They are purpose built facilities and provide inpatient mental health services for up to 128 adults aged 18 years and over.

Summary of findings

St Andrew's Healthcare Birmingham is an independent hospital which provides medium and low secure support for people with mental health needs and / or autistic spectrum conditions. The hospital is registered to accommodate up to 128 people and is made up of eight wards. There is one ward, Moor Green, which is for women only.

Staff in all wards were caring and compassionate. We saw that they worked positively with people and supported them well.

There were policies in place to make sure that patients were safe. We found that staff worked well together to meet people's needs and that they were able to respond to individual needs and preferences.

Staff said that they were supported by managers and senior managers, which helped them to feel valued.

Good

Long stay/forensic/secure services

Are long stay/forensic/secure services safe?

Summary of findings

- We found that medicines were managed safely on the wards. However, we found that medicines in the pharmacy were not stored and disposed of safely.
- There were enough staff to provide safe care. The number of staff was increased to meet people's needs and ensure their safety. However, we found in Speedwell ward that most staff did not take their breaks, which could impact on people's safety.
- We found that systems were not in place in the kitchen used by the people in Northfield ward to ensure that food was safely stored.
- The seclusion room in Northfield was not safe at the time of our inspection but was made safe following this. In Edgbaston ward the seclusion room intercom was not clear so that people using this were not able to hear staff and summon assistance if needed.
- Staff had received safeguarding training and demonstrated that they knew how to protect people from harm.
- Staff were trained in managing violence and aggression. We found that restraint was used safely and only as a last resort.
- There were no ligature risks on the wards, which helped to ensure people's safety.

Our findings

Safe and clean ward environment

We observed that staff were able to observe all parts of the wards to ensure the safety of people who used the service. In Northfield ward there were some areas that could not be clearly seen from the office windows. Therefore, mirrors were provided in these areas so that staff could observe all parts of the ward and ensure that people who used the service were safe.

We saw that there were no ligature points around the wards, which helped to ensure people's safety. Audits of ligature points were completed annually. Staff told us these would be done more often if changes were made to the environment to ensure that all risks were reduced.

Staff told us that the emergency bag held on Edgbaston ward was used when needed for two other wards: Hawkesley and Hazelwell. Hawkesley was opposite Edgbaston ward. However, Hazelwell was in another building. Staff told us that it would take a minute to get there in an emergency although they had not tested this for a few years. We discussed this with the Hospital Director and by the end of this inspection, an emergency bag had been purchased for use on Hazelwell ward. We saw that the emergency bag was tested weekly to ensure that all equipment was safe to use.

In all wards but Northfield, the seclusion room allowed clear observation, had toilet facilities and a clock that displayed the correct time. In Northfield ward there was no mattress and the room was very cold. If a person was using the toilet in the seclusion room or was sitting behind the toilet door that it was not possible for staff to observe them. This could put the person at risk of harm. Staff told us that as it was a low secure ward, this room would rarely be used and had not been used since the ward was refurbished in July 2014. We raised our concerns with the Hospital Director that people's safety would be at risk when using this room. They responded and ensured that by the next day a mattress and a mirror were provided. They also planned to have a camera installed so that staff would be able to view the person in all areas of the room to ensure their safety.

In Edgbaston ward there was not an intercom inside the seclusion room but people would have to summon staff assistance by going to the window. This could put people at risk of harm. There was no mattress on the bed in the extra care area that was next to the seclusion room. We saw that this room was ready for use if needed and staff said it was used. They told us that they would ensure a mattress was provided.

The wards were clean. People who used the service told us this was usual. During our visit the housekeeper supervisors visited some wards to undertake an audit of the ward cleanliness and maintenance. They told us they completed these audits every three months to ensure that the ward was clean and well maintained. However on Edgbaston ward some people told us that the chairs were not cleaned regularly and we saw that these were stained. People also told us that there were no wipes to clean the pay phone after each use, which would help to minimise the risk of cross infection.

We saw that regular health and safety checks were completed. On each shift one member of staff was allocated to the 'safety nurse' role. This meant that they

checked all ward areas and the perimeter fences and ensured that all visitors were aware of safety procedures to follow. Staff told us that they received training to undertake this role and then had to shadow another staff member at least three times to show they were competent to carry out the role.

A kitchen was provided in Northfield ward that people who used the service had access to. This was used for people to do their own cooking and make their own drinks. We found that there was no member of staff allocated as responsible to check the fridge contents and dispose of any out of date food. We saw that food stored in the fridge was labelled as to what it was but not the date on which it was opened, so it was not clear when it needed to be used by. The temperature of the fridge was not checked to ensure it was at a safe temperature to store food. This could pose a risk to the safety of people who used the service.

In Speedwell ward staff and people who used the service raised concerns about the number of people on the ward. There were 17 people on the day of our inspection and there could be 18 people admitted at one time. The ward is for people who have an autistic spectrum condition who may find being in large groups difficult. This could lead to people becoming anxious which could compromise their safety and wellbeing.

Safe staffing

Staff we spoke with told us that staffing levels had been set according to the needs of the ward to ensure the safety of people who used the service. Rotas we sampled confirmed this. We found that there was a mix of qualified and unqualified nurses to ensure staff had the skills and experience to keep people safe. Staffing levels were generally safe during our inspection. However, in Speedwell ward we saw in staff rotas for August 2014 that on five days there had been two qualified nurses and three unqualified nurses on duty, this was less staff than required. This meant that there were two less unqualified nurses than there should be to ensure the safety of people who used the service. Staff told us that there were always two qualified nurses on each shift. Staff spoken with told us they were stressed and often missed their breaks because there were not enough staff. Staff told us that people who used the service did not have activities or their leave cancelled as they did not take their breaks. The Hospital Director told us that each day staffing levels across the hospital were reviewed. However, the ward manager had refused staff to work on the ward as they had said that unfamiliar staff could unsettle people who used the service due to their autism. The ward manager confirmed that staff often did not take breaks and neither did they. Staff worked 12 hour shifts so without a break this could increase the risk of harm to staff and people who used the service.

Staff told us that extra staffing was provided when needed to ensure that people were supported to attend appointments or have extra observation if unwell. This was confirmed by rotas we looked at.

Rotas showed that bank staff were used to fill the gaps because of staff vacancies or sickness. Bank staff told us that they worked on the ward regularly and knew how to safely support the people who used the service. Bank staff we spoke with showed a good knowledge of individual patient needs and how to meet them. They told us they had received an induction and the training they needed to safely support people. Staff told us, and records showed, that all staff, including bank staff, received regular clinical supervision and were well supported.

Several people told us that activities and leave off the ward were often cancelled due to staff shortages. We saw and staff told us that sometimes leave was postponed but not cancelled. However, staff recognised that this could have a detrimental impact on the wellbeing of people who used the service.

Assessing and managing risk to patients and staff

Records we sampled showed that risk assessments were completed when a person was admitted to the ward. We saw that staff completed risk assessments before a person had leave off the ward and when using the garden.

Staff told us that they were aware of the observation policies and had received these during their induction. One ward manager told us that procedures were implemented, where needed, to ensure that people were not kept on constant close observations longer than needed to ensure their privacy.

Staff and people who used the service told us that restraint was rarely used on the wards. We checked restraint records on Hurst ward and found, in line with what staff told us, the most recent restraint had been carried out over two months ago.

Staff told us that they reduced the risks of needing to use restraint by ensuring staff were available to support people.

Good

Long stay/forensic/secure services

They also said that people who used the service were offered regular one to one sessions with staff to talk about how they were feeling and de-escalate any behaviours that could be a risk to people's safety. We saw in records sampled that detailed plans were in place that stated how a person would be restrained if needed. This included the person's physical health needs to ensure they were not at risk when being restrained. All staff received training in managing violence and aggression. This was updated yearly to ensure staff had the skills and knowledge to keep people safe.

We saw and staff told us that rapid tranquillisation was not used on most wards. In Edgbaston ward, some people were prescribed medicines to help with extreme episodes of agitation and anxiety. These medicines were prescribed to be given only when other calming techniques had been used by staff. The ward manager said, "we look at all other causes for the person's behaviour, medicine is not the first answer here." Arrangements were in place to provide guidance to medical and nursing staff for using rapid tranquillisation. We found people were physically checked for their own safety following administration of medicines for rapid tranquillisation and this was recorded in their care records.

People who used the service and staff told us that seclusion was not often used. One person in Edgbaston ward told us, "the last thing they want to do here is seclude people, I haven't been secluded since I've been here but I have been in other hospitals." Records sampled included a plan called 'what works for me to avoid seclusion.' We saw that when seclusion was used, there were clear records kept that ensured the safety and wellbeing of the person who used the service. The person's risk assessment was updated following the seclusion to ensure their safety and that of others.

Staff demonstrated that they knew how to make a safeguarding alert. We saw that staff had made a safeguarding alert when appropriate to ensure that people who used the service were safeguarded from harm. Staff told us and records showed that all staff received training in safeguarding vulnerable adults from abuse. This training was updated yearly to refresh staff knowledge and ensured the safety of people who used the service.

We found that medicines were stored and managed safely on the wards. We saw records that showed medicines were kept at suitable temperatures. However, we found that a large number of controlled drugs (CDs) which were no longer required were stored in the pharmacy. CDs are medicines that require extra checks including special storage, recording and disposal arrangements. The provider had not followed their own controlled drugs procedure, dated June 2014, regarding regular disposal of CDs to prevent the build-up of supply.

Medicines were not stored securely. We found the pharmacy room which stored medicines was not locked. We also found that the available medicine storage cupboards in the pharmacy did not meet safe medicine storage requirements or follow the hospital's own medicine management policy dated February 2014.

Reporting incidents and learning from when things go wrong

Staff that we spoke to were aware of when to report an incident. We saw that incidents had been reported appropriately. Staff told us that following an incident they reflected on how they had responded to it and what they could do better. This meant that staff learnt from incidents to ensure their safety and that of people who used the service.

Arrangements were in place to record any medicine incidents or errors. We found that although there was an open culture of reporting medicine errors, nursing staff were not always informed of the overall outcomes in order to learn and change practice. The learning from these incidents would help to improve the safety of people who used the service.

Are long stay/forensic/secure services effective?

(for example, treatment is effective)

Summary of findings

- People were not consistently supported to participate in regular activities.
- People's physical health needs were assessed and monitored to protect their health and wellbeing.
- Staff received the training they needed to meet people's needs.
- Staff worked well together to meet the needs of patients.
- Systems were in place to ensure that the Mental Health Act was used effectively.

- People's mental capacity was assessment.

Our findings

Assessment of needs and planning of care

Records sampled included a care plan that was up to date and showed staff how to support the person to meet their needs. Care plans were focused on the recovery of the person who used the service. Two specific examples of treatment and support we looked at showed the people were making progress in respect of particularly challenging aspects of their care needs. Staff were clear and consistent in their responses to how these needs were being addressed. People's physical health needs were monitored. People who used the service told us that they had physical health checks. One person told us how they were supported by staff to attend regular appointments to manage their medical condition. Staff we spoke with showed a good awareness of individual physical health needs and how they were managed.

Best practice in treatment and care

We found that people received psychological therapies where needed to meet their needs.

Offender treatment was offered to individuals where needed in Speedwell ward and not in groups. This meant there was treatment tailored to meet the needs of people who would benefit from one to one rather than group work.

People told us they had access to physical healthcare. We saw that, where needed, referrals were made to specialists to ensure that people's physical health needs were met.

Staff told us that an audit had been completed in the hospital that showed that people who used the service were gaining weight following their admission to the hospital. In response to this the health professionals, including the dietician, had put in place a diet plan to ensure that people's physical health needs were not affected. People who used the service told us that they could understand some restrictions may be needed but felt this should be supported by regular access to physical exercise. They told us that they could not always go to the gym because staff were not available to escort them. Staff agreed with this but told us that gym equipment was being provided on the wards to help ensure that people had regular opportunities to exercise and promote their physical wellbeing.

Activities on the ward were provided and we saw some people playing pool and table tennis with staff. However, several people told us they were bored. One person told us that all they did was play cards. We observed that some people were sat around the ward not participating in any activity.

Staff and people who used the service told us that at weekends there were few activities provided. Staff told us this was because of the shortage of occupational therapists (OT) although these posts were being recruited to. People told us that some people could not leave the ward due to the risks to their safety and that of others. They said that this meant that limited activities were provided. We saw that a sensory room was provided on Edgbaston ward and staff told us that the OT did a project with people who used the service and they converted this room. However, people told us this room was not used often. One person told us, "there are excellent facilities in this hospital but we can't always access them due to staffing." on some wards there were not sufficient staff currently trained in gym use to be able to support people without a trained gym instructor being present. This meant some people were unable to use the gym as often as they wished. Staff told us there were plans to have gym equipment such as cycle machines available on wards.

Some people told us they had done some gardening, did their own laundry and sometimes cooked their own meals with support from staff, which helped to reduce their boredom. We saw that people in Northfield ward had access to external college courses and work placements. Some people worked on a local allotment which they said they enjoyed.

Skilled staff to deliver care

A qualified occupational therapist (OT) and a technical OT instructor was provided.. Recruitment was in place to increase this compliment to help improve people's opportunities to access regular activities particularly at weekends and in evenings.

Rotas showed and staff told us that there was always at least one qualified nurse on each shift. There were usually at least two qualified nurses on day shifts. Staff told us they received the training and supervision needed to ensure they had the knowledge and skills to meet people's needs. In Speedwell ward this included training for all staff in autism.

Good

Long stay/forensic/secure services

Multi-disciplinary and inter-agency team work
Staff told us and records showed that between each shift there was a handover. This meant that staff knew what support each person needed to meet their needs.

We observed on some wards meetings taking place between the multi-disciplinary team (MDT) of professionals that worked there, which reviewed the care and treatment that people who used the service received. We saw that the person was involved in the meeting about them and the MDT worked together well to ensure the person's needs were being met. Most staff told us they were involved in these meetings. However, some staff in Speedwell ward told us they rarely attended these even though they had worked on the ward for years. This could mean that the views of all staff that supported the person on a daily basis were not considered which could impact on how people's needs were met.

Staff told us they had developed good links with people's care co-ordinators. This meant that all agencies worked together to ensure people's care and treatment was effective.

Adherence to the MHA and the MHA Code of Practice
We saw that people who were detained there under the MHA had the appropriate documentation in place for consenting to their treatment including medicines. Where people had been prescribed treatment without their consent, because they did not have the mental capacity to do so, or had refused to, we saw that a second opinion appointed doctor (SOAD) had seen them and stated that it was appropriate for treatment to be given.

Records we sampled showed that people's forms for when they had section 17 leave from the ward had been completed appropriately. These included a risk assessment completed before the person went on leave to ensure their safety and wellbeing.

Records we sampled showed that staff had attempted to explain to people their rights under the Mental Health Act (MHA). Six records we sampled showed that the person had refused this. However, staff had recorded that the person had understood their rights. This could mean that staff might not make further attempts to explain these to ensure that people were aware of their rights. One person's record in Speedwell ward clearly stated that the person did not understand these but no attempt had been made to inform the person in a way that was accessible to them. People had used their right to an appeal of their detention under the MHA. The checklist that staff used for informing people of their rights had two of these rights missing. These were the right to see the MHA code of practice and access to an independent mental health advocate (IMHA). This could mean that people were not aware of these and we found that few people who used the service accessed the IMHA.

Good practice in applying the MCA
All records we sampled included an advance statement that was completed with the person as to how they wanted to be treated.

Records showed that for all but two people in Speedwell ward, detailed assessments had been completed of each person's mental capacity to consent to their treatment. However, each person had an overweight/obesity plan to help them to lose weight and promote their physical health needs. Records did not show that the mental capacity of the person had been assessed to consent to this. Only two of the plans showed that the person had consented to this. We saw that a decision had been made for one person, who lacked the mental capacity to consent was in their best interests and in accordance with the MCA.

Are long stay/forensic/secure services caring?

Summary of findings

- Staff were caring and compassionate, and they were motivated to make sure that people were well supported.
- All visits to people were supervised by staff which impacted on people's privacy.
- Patients were treated with dignity and respect.
- Most people were involved in their care and treatment plans. However, some people in Speedwell were not always involved in this care as information was not provided in a format they could understand.

Our findings

Kindness, dignity, respect and support.
We observed respectful and positive interactions between staff and people who used the service. One person said, "the staff are good here, it's a nice atmosphere and I feel like a weight has been lifted off my shoulders in here."

Good

Long stay/forensic/secure services

All people spoken with told us that staff were caring and that they listened to people. One person who used the service told us, "it's the best hospital I've ever been in." Another person said, "staff offer a high standard of care." one person told us staff were "superb". Another person said that they thought staff were much more approachable at events such as summer fetes than they were on duty.

Staff demonstrated that they had an understanding of the individual, cultural and religious needs of people who used the service. There was a diverse mix of staff that reflected the diverse mix of people who used the service.

The involvement of people in the care they receive
People who used the service showed us round their ward. They told us that they often showed new people admitted to the ward around to help them to know about the ward and find where everything is.

People told us that they were involved in their care plans and had a copy of these. One person said, "staff sit with me and review my care plan with me, then I sign it." We saw in records we sampled that people were involved in most of their care plans and had signed to agree to these. In Speedwell ward we found that care plans were not in a format that was accessible to people who used the service. This did not enable people to be involved in their care plan and staff told us that most people were not involved in these.

People told us that the community meetings held on the ward were helpful and staff listened to them. People who used the service and staff told us that people were involved in interviewing new staff. In Edgbaston ward staff and people who used the service told us that people were involved in developing the ward 'rules'. Staff told us that this helped people to 'own' these and follow them more often. They also said that the 'rules' applied to staff not just people who used the service and this was important in respecting people.

Staff, people who used the service and their relatives told us that all visits were supervised by staff. Some people and their relatives told us they did not understand the reasons for this. We discussed this with the hospital director who agreed to ensure that visits would be risk assessed for individuals to ensure that people's privacy was not compromised unnecessarily.

We spoke with a small group of families and carers. They told us there was a carers group set up that met regularly, although attendance was difficult for some relatives who lived a distance away. One person had travelled a hundred miles to be present. They felt information and communication was a problem. They told us they felt there was very little information for relatives and carers when a person was first admitted to St Andrew's. People who used the service told us that they sometimes had difficulty accessing the independent mental health advocate (IMHA). There was one IMHA who provided a service to all people at the hospital to ensure their views were listened to. Some people told us that this meant that they could not always obtain advice from an IMHA. One person's records we sampled had frequent contact and support from the advocate. Some people told us they had little contact with the advocate, as she was busy with other people.

People who used the service spoke positively about the care they received from staff. One person said, "coming here has been the making of me."

Are long stay/forensic/secure services responsive to people's needs?
(for example, to feedback?)

Summary of findings

- Staff worked with community teams to plan people's discharge from hospital.
- All people were searched on return from leave regardless of their assessed risks.
- Wards were generally comfortable. However some improvements could be made. We found that Speedwell ward was big, which did not always positively respond to the individual needs of people with autism.
- The service met people's religious and gender-specific needs.
- Staff had access to good interpreting services. This meant that people could communicate their needs effectively, and staff knew how to respond.
- We found that concerns or complaints were dealt with and improvements made where needed.

Good

Long stay/forensic/secure services

Our findings

Access, discharge and bed management

We found that people were not moved around the wards unless it was in their interests and part of their care pathway. For example, some people told us that they had moved from the medium secure wards to the low secure wards as they had progressed in their treatment.

We were told that beds were not used when a person was away on leave and saw no evidence to contradict this. People were only moved for one ward to another for valid clinical reasons. We were made aware of situations where people had used a seclusion room on a ward other than their own on a few occasions.

We saw that discharge of a person from the ward was discussed in MDT meetings. This was not delayed unless there was a reason why it was not in the person's interests to be discharged.

For example, we found one person's discharge from the hospital had been delayed. We spoke with staff and looked at the person's records. We saw this was because the identified accommodation for the person to move to was not appropriate to meet their needs. Therefore, it was not in the person's interest to move there. Further accommodation was being sought to ensure their discharge would be suitable.

The ward environment optimises recovery, comfort and dignity

Northfield ward was refurbished in July 2014. We observed and people who used the service told us that the ward was comfortable and there were different areas where people could relax.

There were adequate rooms where activities and therapies could be provided in Hawkesley ward. There was a gym adjacent to the ward so that people who did not have leave out of the ward area could access this.

We saw that Speedwell ward was very big and provided a service for up to 18 people. Staff and people who used the service told us that this was too many people and did not help to meet people's specific needs.

In Edgbaston ward we saw that a range of rooms were provided where people could do different activities. However, people told us that access to these was often limited as staff were not available to support them when using them. Some people told us that the lights were too bright, which meant that in the evenings it was not a relaxing environment. We saw that the walls were painted in the same colour and there were few pictures to make the environment relaxing. One person told us, "it's clinical, not comfortable." We saw that stools were provided in the dining room. People told us that these were uncomfortable. One person told us that they had requested that small tables be provided around the ward to put drinks on. They recognised that this could be a risk and the tables may need to be secured to the floor but they did not think that this needed to be an obstacle in providing them.

We saw that people could make a phone call in private and people said they used the phone when they wanted to.

On all wards there were set times where people were supported by staff to go outside the ward. People told us that the hospital plan was to reduce this to six times a day so these breaks did not affect therapeutic activities. One person said this did not bother them. However, some people expressed concern that this did not give them enough time to go out of the ward if they had no other leave granted.

All wards were single sex and all bedrooms had an ensuite shower and toilet.

Some people told us that they disliked the food and the choice was limited. They told us that there was a menu which changed according to the seasons but this was repetitive. However, some people told us that the food was good and they thought the menu was varied. Some people told us that the food portions had been reduced to try to support people to lose weight and promote their physical health. Staff told us that this had resulted in confusion for some staff and they had not known whether or not to give further portions if people wanted them. However, they told us that further portions of fruit and vegetables were always available and all staff had now been informed of this.

People told us that they could make drinks when they wanted them and had access to snacks.

Ward policies and procedures minimise restrictions

In Northfield ward people who used the service told us that they did not have the keys to their bedroom or the lockable space in their bedroom. They said that they had to ask staff for the key each time they wanted their bedroom unlocked. One person said, "it's a bit embarrassing, you have to ask someone to go into your bedroom. This is supposed to be a

step down ward as well." The hospital operated a risk policy and people moved between the different levels depending on the risks to their safety and wellbeing. The policy stated that if a person was on this ward that they would be able to have a key to their bedroom. Staff told us that keys had not been available since the ward was refurbished and thought this was an unacceptable delay. The hospital director explained that there had been a problem with the key supplier but told us this would be done to ensure that people's independence was promoted.

Each ward had a small kitchenette so that people who used the service could make hot drinks. We saw this was locked on Hurst ward. A staff member told us this was because at least one person who used the service was at risk from having too much sugar. We queried why the kitchen could not be left open and just the sugar locked away, so people could make hot drinks at any time and only had to ask for sugar. We saw that staff responded promptly to requests to use the kitchenette.

In all wards we saw that people could only go outside the ward into the garden when supervised by staff. Staff we spoke with were unsure why access to the garden was restricted for some people. It was not clear in people's records we looked at why some people had regular unescorted access in the community but could not go out in the garden when they wanted to.

All people who used the service were searched when they returned from leave. Staff told us this was for safety and security reasons and gave us examples of contraband items being smuggled into the unit various ways. We queried whether a regime of random searches may be more effective. None of the people who used the service that we spoke with complained of the search procedure. Managers and staff told us that many restrictions, such as on the 'trading' of items, were in place to protect more vulnerable people from being exploited by others.

We saw that people were able to personalise their bedrooms.

Meeting the needs of all people who use the service

Staff and people who used the service told us that interpreters were provided if needed to help people understand their care and treatment. They told us that these were always available. There were staff who spoke a variety of languages other than English.

Staff and people who used the service told us that there was a choice of food that met people's religious and cultural dietary needs.

Listening to and learning from concerns and complaints

People told us they knew how to complain. They said that these complaints would be listened to and action taken to make improvements where needed.

Are long stay/forensic/secure services well-led?

Summary of findings

- The hospital's medicine management policies were not followed by pharmacy staff.
- Staff were generally well supported by their managers and by the senior management. Staff in Speedwell ward were not supported to take their breaks. There were insufficient occupational therapy staff which led to some staff feeling unsupported.
- People's personal information was not always kept confidential and handled appropriately.
- Patients were listened to and, as a result, improvements made.
- Staff had opportunities to develop their skills and knowledge.

Our findings

Vision and values

Staff and patients told us that the Executive Team of the charity had visited and listened to their views. Staff told us that the Chief Executive contacted them through email weekly and there was an opportunity for staff to respond to this. Staff told us that the Hospital Director visited the wards regularly and spoke to staff and patients who used the service. There were also opportunities to meet with the Hospital Director if staff and patients wanted to. We saw that the Hospital Director knew the patients by name and had an understanding of their needs.

Vision and values

Staff and people who used the service told us that the executive team of the provider had visited and listened to their views. Staff told us that the chief executive contacted them through email weekly and there was an opportunity for staff to respond to this. Staff told us that the hospital director visited the wards regularly and spoke to staff and

people who used the service. There were also opportunities to meet with the hospital director if staff and people who used the service wanted to. We saw that the hospital director knew the people who used the service by name and had an understanding of their needs.

Good governance

We saw and staff told us that they received regular training and supervision to undertake their job role. However, some staff told us that there were more training opportunities available at the Northampton site which meant that staff needed to travel to receive this training.

We saw that a sufficient number of nursing staff of the right grades and experience covered the shifts. However, there were insufficient occupational therapists (OTs) employed to ensure that people were engaged in regular activities. OTs told us they were not always supervised because of this. They said these posts were being recruited to.

The Pharmacy team consists of two part time pharmacists one of these posts was vacant and one full time pharmacy technician.

The pharmacy team had regular team meetings and joint meetings with pharmacy staff held at the Northampton site, staff who could not attend were encouraged to join by telephone or video conference.

We saw that several people who used the service attended community meetings and were able to express their views. However, we saw in minutes on Northfield ward that a number of requests to improve the ward had been delayed as the ward manager was off sick. Several items noted that the ward manager needed to approve requests on their return to the ward. This meant that people's views had not been actioned to improve the ward for their benefit.

We saw that one person in Speedwell ward had requested that some of their medical information be kept confidential and not shared with all their relatives. The person told us that their confidentiality had been breached and they were upset about this. We found that their request had not been passed to the hospital director who was the Caldicott guardian for the hospital. A Caldicott guardian is a senior person responsible for protecting the confidentiality of a patient and service user information and enabling appropriate information-sharing. This meant that the correct procedures had not been followed to ensure that people's personal information was kept confidential.

We found that the Mental Health Act (MHA) Administrator regularly scrutinised the MHA detention papers.

We saw that the hospital policies for the safe storage of medicines were not followed which could put people at risk of harm.

Leadership, morale and staff engagement

Staff told us that they worked as a team and were well supported by managers. They said this enabled them to do their job to benefit the people who used the service. Staff spoken with told us that they felt able to raise any concerns they had without fear of victimisation.

We found that staff on Speedwell ward did not take their breaks as there were not sufficient staff to cover these. They told us that this reduced their morale and led to them feeling unsupported.

Commitment to quality improvement and innovation

Ward managers spoken with told us that the outcomes of directors' meetings were fed into the quality compliance meetings that all ward managers attended. The ward managers then ensured that this was fed back to staff and people who used the service and their responses fed back to the directors. They said that this ensured that the views of people who used the service were listened to. One ward manager told us that they did not receive feedback from audits which meant that they did not know how the service needed to improve.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **How the Regulation was not being met:** The registered person had not protected people against the risks associated with the unsafe use and management of medicines, because they had not ensured all medicines were disposed of appropriately. Regulation 13