Requires improvement

Leicestershire Partnership NHS Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT5KF	The Bradgate Mental Health Unit	Herschel Prins Clinic	LE3 9DZ

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

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

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement 
Are services safe?	**Inadequate** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We gave an overall rating for forensic/secure wards of **requires improvement** because:

- Ligature risks had been identified in bedrooms, bathrooms and toilets but there was no clear action to address all of the identifed risks
- The seclusion rooms had known blind spots but no action had been taken to reduce them. The bed in the seclusion room on Phoenix was too high and a patient had used it to climb up to windows and to block the viewing pane
- Care plans and risk assessments did not show staff how to support patients. Staff were inconsistent in updating the Historical Clinical Risk Management (HCR-20) assessments.
- Staff did not demonstrate a good understanding of the Mental Health Act (MHA) and Mental Capacity Act (MCA). Patient's capacity to consent to their treatment had not been assessed in some cases
- Patients' physical health was checked on admission but patients did not have access to a GP for ongoing monitoring or treatment of their health
- The telephone for patients' use was situated in a corridor and did not provide patients with sufficient privacy
- We identified that staff did not always take a person centred approach to care and did not always take positive risks when this might have been indicated
- The forensic services staff said they felt lost and did not know where they were going strategically

Summary of findings

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

Are services safe?

Inadequate

We rated safe as **Inadequate** because:

- The layout of the seclusion rooms meant that staff could not observe patients in seclusion at all times to ensure they are safe. Staff had taken no action to improve observation. Staff had to enter the seclusion room to open the toilet for patients to use. The bed in the seclusion room on Phoenix was too high and a patient had used it to climb up to windows and to block the viewing pane
- Ligature risks had been identified in bedrooms, bathrooms and toilets but there was no clear action to address all the identifed risks. Individual care plans did not show staff how to diminish these risks
- The staff skill mix did not match the trust's preferred mix of 60% qualified, 40% unqualified per shift
- Repairs were not carried out in a timely way to avoid the damage to the wards impacting on patients
- Response to emergencies out of hours by on-call doctors was not quick enough

However:

- Staff used de-escalation techniques to calm patients when required and restraint was used as a last resort
- Staff regularly checked the emergency resuscitation equipment and it was kept in a place where it was accessible
- Staff had been trained in safeguarding and knew how to make a safeguarding alert
- Appropriate arrangements were in place for the management of medicines
- The wards were clean

Are services effective?

Requires improvement

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

- Assessments were not completed in a timely way following admission. We could not find care plans for some patients. Risk assessments were not updated regularly to reflect patients current risk levels. Patients' notes and documentation were missing and could not be found
- There was no clear model of care in use on the wards

Summary of findings

- Initial physical health assessments were done on admission however regular checks was not completed for patients. Some patients did not have access to a GP service to manage their physical health
- There was limited psychological treatment to patients on the ward. There was limited occupational input to the activities on the wards
- Consent to treatment forms were not all completed by the current Responsible Consultant, (RC)
- There were no audits to ensure the MHA was properly applied

However:

- An electronic prescribing and administration system was in place. Medicines interventions by pharmacist were recorded on the system to guide staff
- There was a multi-disciplinary team working in the clinic
- Statutory and mandatory training was kept up to date and monitored through an electronic system. Training in MCA was part of the trust statutory and mandatory training programme

Are services caring?

Good

We rated caring as **Good** because:

- Patients were positive about staff. We observed good interactions between staff and patients
- Staff showed that they knew about patients' needs and how they help them
- We saw that staff and patients eat together on Griffin ward
- Patients were introduced to the ward on admission
- Patients were involved in their ward reviews
- There was access to advocacy services
- Wards hold daily community meetings where patients can discuss concerns and choose activities for the day

However:

- Patients were not happy with the lack of privacy during visiting times
- Patients were not always involved in their ongoing care planning
- There was no regular auditing of patients views about the service

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

- A blanket restriction was in place about visiting as all visits had to be observed
- Patients did not have privacy during telephone calls because of the location of patient's phone
- On Phoenix ward the patients' kitchen did not have a fridge for patients to store goods that needed to be kept cool like milk
- Patients who had been on the wards for a long time complained that the menu was boring and repetitive.
- There was poor communication between the teams resulting in planned sessions having to be cancelled

However:

- There were regular meetings to discuss new referrals to the clinic
- All admissions were planned in advance
- Patients experienced a stable stay in the clinic with no movement of beds due to bed demand
- The location of the wards allow for people with a disability to access the wards without any difficulty
- Patients knew how to make a complaint

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- Staff at ward level did not understand the vison and values of the trust
- The ward and organisation values were not set in practice
- The governance systems looked at quality and safety but had not addressed identified risks in the clinic
- Supervision when planned is not always delivered
- Qualified staff spend most of the shifts involved in office duties
- Staff reported bullying by other staff on the wards
- Some staff said forensic services felt lost and did not have a strategic direction
- Morale was described as variable across the clinic

However:

- Senior managers knew the vision and values of the trust.
- Immediate line managers were well known to staff.
- There were local forums that discussed aspects of care in the clinic.
- Matrons had autonomy to vary the staffing according to needs.
- Training was monitored to ensure staff were up to date with their statutory and mandatory training.

Summary of findings

Information about the service

The forensic/secure wards, Phoenix and Griffon are based in the Herschel Prins Clinic on the Glenfield hospital site. Each unit is single gender accommodation.

The Herschel Prins clinic is a low secure unit that has two wards and a total of 18 beds; (12 beds for men and 6 beds for women). The length of stay for patients was between 18 months and two years. Referrals to the unit came from medium secure services, psychiatric intensive care wards, out of area units that Leicester patients were placed in and from acute wards in the trust.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection Managers: Lyn Critchley and Yin Naing

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers and support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting

The team that inspected the Forensic/secure wards consisted of eight people: two inspectors, two nurses, two Mental Health Act reviewers, an occupational therapist and a consultant psychiatrist.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information, and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- Visited both wards at the hospital site and looked at the quality of the ward environments and observed how staff were caring for patients
- Spoke with 12 patients
- Spoke with the matron for each of the wards
- Spoke with the clinic manager
- Spoke with 14 other staff members: including doctors, nurses, an occupational therapist, and a psychologist
- Attended and observed two community meetings and one multi-disciplinary meeting
- Looked at 14 treatment records of patients.
- Carried out a specific check of the medication management on both wards.

Summary of findings

- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Looked at 14 patients' medicine charts.

What people who use the provider's services say

Some patients were positive about their experience of care. They told us that most staff were caring, kind, friendly, and treated them with dignity and respect. They said that staff always knock and wait to be invited into their bedrooms. Two patients told us that staff were unapproachable and not helpful when they needed help.

Patients told us that the qualified nurses spent a lot of their time doing paper work which meant they did not spend much time with them.

Patients said they did not feel safe on admission however as they got to know people they become comfortable on the wards. They also said they had not experienced much aggression from other patients and when someone did become aggressive staff managed the problem.

Patients said that when they have visitors they do not get any privacy because their visits are observed. One patient said they did not like the ward because everything is very restricted and locked up.

They told us the food is "alright but gets a bit boring''.

Areas for improvement

Action the provider MUST take to improve

- The trust MUST remove ligature risks from the wards
- The trust MUST reduce the blind spots in seclusion rooms so that staff can observe patients at all times when secluded
- The trust MUST put systems in place to ensure that patients' capacity to consent is assessed and their human rights are protected
- The trust MUST ensure that care plans and risk assessments are sufficiently detailed so that all staff know how to support each patient safely and must record patients' involvement
- The trust MUST make patient information available for all staff to access
- The trust MUST ensure that all staff receive training and supervision to ensure they are able to meet patient's needs

Action the provider SHOULD take to improve

- The trusts should carry out a risk assessment to patients when building and repair work takes place in the clinic
- The trust should ensure that more psychological and occupational therapy is available to patients on the wards
- The trust should improve communication between staff to avoid confusion about services available to patients

Leicestershire Partnership NHS Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Herschel Prins clinic	Bradgate Mental Health Unit

Mental Health Act responsibilities

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

The documentation in respect of the Mental Health Act varied. Most of the section 17 leave forms detailed the time of the leave and whether this was escorted or unescorted. Patients section 17 leave had not been well monitored because no review dates were entered onto the form. We did not see evidence that patients or their relatives had been given copies of their leave forms.

Staff routinely explained to patients their rights under the Mental Health Act. We found these were not repeated to patients to ensure they understood them. Information was provided to patients about their rights in leaflets which were produced in other languages where needed.

Patients were referred to the Independent Mental Health Advocate (IMHA) service where appropriate.

Patients were treated under T2 forms completed by another responsible clinician at a previous ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff did not demonstrate a good understanding of MCA and DoLS. The majority of staff felt they did not have any responsibility in MCA and did not know how the legislation applied to their work with patients.

Staff were not aware of the policy on MCA and DoLS.

A senior manager confirmed the trust did not train all staff in MCA and DoLS to provide them with knowledge required in applying the legislation appropriately. Most of the staff were not able to tell

us who they would contact as the lead person on MCA within the trust.

The use of the Mental Capacity Act was not monitored by the wards.

Inadequate

Are services safe?

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

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

Summary of findings

We rated safe as **Inadequate** because:

- The layout of the seclusion rooms meant that staff could not observe patients in seclusion at all times to ensure they are safe. Staff had taken no action to improve observation. Staff had to enter the seclusion room to open the toilet for patients to use. The bed in the seclusion room on Phoenix was too high and a patient had used it to climb up to windows and to block the viewing pane
- Ligature risks had been identified in bedrooms, bathrooms and toilets but there was no clear action to address all the identifed risks. Individual care plans did not show staff how to diminish these risks
- The staff skill mix did not match the trust's preferred mix of 60% qualified, 40% unqualified per shift
- Repairs were not carried out in a timely way to avoid the damage to the wards impacting on patients
- Response to emergencies out of hours by on-call doctors was not quick enough

However:

- Staff used de-escalation techniques to calm patients when required and restraint was used as a last resort
- Staff regularly checked the emergency resuscitation equipment and it was kept in a place where it was accessible
- Staff had been trained in safeguarding and knew how to make a safeguarding alert
- Appropriate arrangements were in place for the management of medicines
- The wards were clean

Our findings

Herschel Prins clinic

Safe and clean ward environment

- The design and layout of the majority of the wards did not allow for clear lines of site. Areas of the ward that could not be seen were managed through regular observation checks carried out by nursing staff.
- The seclusion rooms on both wards contained blind spots. On Phoenix ward staff knew about the blind spots and told us a mirror had been ordered to create full viewing of the room. On Griffin ward seclusion room the toilet door when open blocked the viewing window into the toilet and washing area. The doors to the toilet and wash areas in both rooms had to be manually opened. This meant that staff had to enter the seclusion room to allow access to the toilet and wash area.
- Griffin ward had an extra care area with the seclusion room next to that area.
- The bed on Phoenix ward was not fixed and was of a height that patients could use to reach the window or to block the viewing pane in the door. Staff told us that patients had used the bed to climb up to the window and to block the viewing pane in the door. When we raised this with staff they told us the bed would be removed and replaced with an appropriate bed.
- There were ligature risks throughout both wards. In bedrooms, toilets and bathrooms we saw taps that were ligature risks. The trust had taken action to address some of the ligature risks identified, such as anti-ligature door handles, and wardrobes. It was not clear when plans to reduce identified ligature risks would be implemented. Bids had been made for capital monies to eliminate the remaining ligature risks but the decision to award the funding had not been agreed at the time of our inspection.
- There had been a recent incident on Phoenix ward where a patient had tried to self-harm with a ligature. However, care plans did not detail how staff were to support each patient at risk so that the risks would be reduced. Staff described how to reduce the risks but it was not clear how this information was passed to all staff who worked on the ward.

Inadequate

Are services safe?

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

- The wards and therapy rooms were all clean, tidy and maintained to a good standard. We saw domestic staff working in the wards and clinic during our inspection. Patients we spoke to said they were satisfied with the cleanliness of wards and rooms they used in the clinic.
- One patient had a hole in their bathroom wall which prevented them using their shower. This hole had been there for two months and had not been fixed.
- We were told that the clinic room on Phoenix had had severe drainage problems with sewage flowing into the room from the sink on a couple of occasions. The room was cleaned and signed off fit to use by health & safety and the infection control nurse. Interserve, the trusts' estate contractor, was coming to survey pipes in the grounds that were said to be the source of the problem. However this had taken longer than should be expected.
- There were appropriate alarms and call systems throughout the wards. To comply with policy and to ensure safety, the inspection team were given alarms during the visits to the unit.

Safe staffing

- The trust had assessed the nurse staffing requirement for Phoenix ward as 2 qualified nurses and 3 healthcare assistants (unqualified) for day shifts and 1 qualified nurse and 2 healthcare assistants (unqualified) for night shifts. When we examined the rotas for the previous eight weeks we found that, although the number of staff on shifts met the assessed requirement, the ratio of qualified to unqualified staff did not always meet this.
- We found that evidence suggested that staffing levels might not be sufficient. For example, we observed that there was not always a qualified member of staff present in the communal area on Phoenix ward. Four patients told us that they did not receive the regular one-to-one sessions with their primary nurses agreed in their care plans. Staff told us that they had previously struggled to provide staff to escort patients on leave. They had instituted group walks as part of leave activities to allow more patients to access their section 17 leave. However, this was not individualised care. On Phoenix ward the matron was able to adjust and maintain additional staffing according to the level patient needs.
- The vacancy rate at the Herschel Prins Clinic was between 22.8%- 30.1% (September - November 2014). The sickness absence rate over the same period was 1.5% – 5.4% (5.4% in November 2014). Both wards used bank and agency staff to cover vacancies and sickness. 40% of the shifts over September 2014- November 2014 had been covered by agency or bank staff. The trust provided a structured induction for bank staff and tried to use staff who were familiar with the ward and the patients.
- On Phoenix ward each day shift there were two qualified nurses and three nursing assistants. At night there was one qualified nurse and two nursing assistants. On Griffin ward each day shift had two qualified nurses and two nursing assistants. Night shifts had one qualified and two nursing assistants.
- There was also support from occupational therapist (OT), available two and half days each week; two activities workers and sports instructor during working days. There was one psychologist shared with the community team.
- The wards were supported by three consultant psychiatrists, (one was a new locum) and a speciality doctor. Staff told us they could easily access medical input during the day. Access to doctors out of hours was via doctors on call. Whilst we were inspecting an incident happened and the duty doctor was called. Inspectors were on site for an hour after the incident but the doctor did not arrive within that time. The following morning we checked the notes and saw that the doctor arrived over an hour after they were called.

Assessing and managing risks to patients and staff

- Following admission we saw that not all patients' had a 72 hour care plan completed. Care plans were continued from other wards that patients came from. Where care plans had been completed they contained information from patient's previous history and focused on how the patient was to be supported. The agreed level of observation, risk assessments, and a plan of care put in place. Patients were reviewed at the weekly meeting with consultant psychiatrists. Where increased risks had been identified there was not always a clear, regularly reviewed care plan in place so that staff knew how these risks could be reduced.

Inadequate

Are services safe?

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

- We looked at patients' notes to check that risk assessments were carried out prior to section 17 leave. We could not locate risk assessments prior to patients going out. We were told that risk assessments prior to a patient taking section 17 leave were not recorded.
- There were substantive procedural security measures and robust operational policies and procedures that were followed by staff and applied to patients and visitors. There were good policies and procedures for the use of observation and we saw staff carrying out regular checks throughout the wards.
- On both wards de-escalation was used and staff gave us examples of how communicating with the patient helped to ensure that the number of restraints used had reduced. Between June and December 2014 there were 16 recorded episodes of restraint on Phoenix ward and 2 on Griffin ward of which one on Griffin ward was in the prone position.
- Seclusion was rarely used. Between June and December 2014 there were 8 recorded episodes of seclusion on Phoenix ward and none on Griffin ward. Staff told us and training records confirmed they had been trained to use de-escalation to avoid the need to use seclusion. When the seclusion room was used, interventions and observations were recorded in the same way as 1:1 observations on a paper record. Patients were seen by a doctor whilst in seclusion.
- All staff had been trained in the physical intervention method used within the trust Management of Actual and Potential Aggression (MAPA).
- The trust rapid tranquillisation policy had been followed by staff that prescribed medicines to be given in an emergency and followed the NICE guidance.
- Training records indicated that all staff had been trained in safeguarding vulnerable adults. Staff demonstrated that they knew how to identify and report any abuse to ensure that patients were safeguarded from harm.
- There were appropriate arrangements for the management of medicines. We reviewed the medicine administration records and the recording of administration was complete and correctly recorded as prescribed. Patients were provided with information about their medicines. Most patients we spoke with confirmed they had received information about medicines and knew what they were for.
- Medicines were stored securely on the units. Temperature records were kept of the medicines fridge and clinical room in which medicines were stored, providing evidence that medicines were stored appropriately to remain suitable for use.

Track record on safety

- In the last year there had been 10 serious untoward incidents involving patients at Herschel Prins centre. The serious untoward incidents had related to two patients who had episodes of seclusion. Staff told us that they always try to de-escalate incidents however they had not been able to distract the patients to prevent them being secluded on these occasions.
- We saw from training records that all staff had completed training in de-escalation and management of violence and aggression.

Reporting incidents and learning from when things go wrong

- There was an effective way to capture incidents, near misses, and never events. Some staff we spoke to knew what and how to report incidents. One person who had recently started working at the unit said they were unsure of how to report incident reporting. Staff received feedback from investigation of incidents through handovers, ward meetings and in supervision. In Phoenix ward staff had not identified the risks to a patient who had self-harmed. The patient's care plan and risk assessment was not detailed to show staff how to identify risks in the future. This did not show that sufficient action had been taken to learn from the incident.

Are services effective?

Requires improvement

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

Summary of findings

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

- Assessments were not completed in a timely way following admission. We could not find care plans for some patients. Risk assessments were not updated regularly to reflect patients current risk levels. Patients' notes and documentation were missing and could not be found
- There was no clear model of care in use on the wards
- Initial physical health assessments were done on admission however regular checks was not completed for patients. Some patients did not have access to a GP service to manage their physical health
- There was limited psychological treatment to patients on the ward. There was limited occupational input to the activities on the wards
- Consent to treatment forms were not all completed by the current Responsible Consultant, (RC)
- There were no audits to ensure the MHA was properly applied

However:

- An electronic prescribing and administration system was in place. Medicines interventions by pharmacist were recorded on the system to guide staff
- There was a multi-disciplinary team working in the clinic
- Statutory and mandatory training was kept up to date and monitored through an electronic system. Training in MCA was part of the trust statutory and mandatory training programme.

Our findings

Herschel Prins clinic

Assessment of needs and planning of care

- Patients' needs were not assessed in a timely way following their admission to the wards. Records showed that patients did not receive assessment soon after admission.
- Care plans were unclear and did not focus on helping patients to recover. We looked at 12 patient files and found that four did not contain a care plan.
- The clinic uses Historical Clinical Risk Management (HCR-20) which is required for forensic patients, as the standard assessment tool. We saw that all 12 files we looked at contained an assessment. However, not all of those assessments were up to date.
- Staff told us that the 'my shared pathway' model was being introduced although we did not see any evidence of its introduction or use on the wards.
- RIO record system had recently been introduced and staff were adjusting to using the system. However we found that staff found patient information such as care plans and Mental Health Act documentation hard to find. A member of staff told us that paperwork could do with improving and "You can't find things".
- Most records showed that patients' physical health was monitored. However, some patient's records did not show that their physical health needs were reviewed after their admission even where risks had been identified.
- We were told that the clinic has not been able to get general practitioners (GPs) to accept Herschel Prins patients onto their lists. Patients from the local area are able to retain their GPs and receive support for any ongoing health issues. Patients without a GP are supported by the trust's doctors. We saw that some patients refused physical health checks when offered by the staff.

Best practice in treatment and care

- The hospital used an electronic prescribing and medication administration record system for patients which facilitated the safe administration of medicines. A pharmacist reviewed the prescription charts each weekday. We saw that pharmacy staff checked that the medicines that patients were taking when they were admitted were correct and that records were up to date. Pharmacists recorded their input on the system to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for three patients on one ward. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records

Are services effective?

Requires improvement

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

showed people were getting their medicines when they needed them. Allergies to medicines to were recorded on the electronic prescribing and medication administration records.

- Medicines, including those requiring cool storage, were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.
- Psychological input was limited because clinical psychologist worked across wards and community. However we saw that patients were offered psychological therapies through groups such as anger management, and problem solving.
- There is inconsistent occupational therapy input to the wards due to sickness absence. We found they had little involvement in therapeutic programme of activities for the unit, much of the activities organised was by two activity workers who had previously worked as health care support workers.
- There was no GP review of patients' physical health within Herschel Prins. The physical health care and reviews was carried out by the junior doctors. One doctor told us that this is a gap in the service provision.

Skilled staff to deliver care

- The staff working in Herschel Prins came from a range of professional backgrounds including nursing, medicine, occupational therapy, and psychology. Other staff from the trust provided support to the wards, such as the pharmacy team.
- Staff received the statutory and mandatory training they needed and where updates were required, this was monitored through an electronic system. Records showed that most staff were up-to-date with statutory and mandatory training. Nurses told us that attending training was difficult due to the pressures on the wards, but that it was prioritised. We saw that all staff that were due for updates were booked to attend training
- Staff in Herschel Prins told us that their formal supervision was often cancelled when regular staff were away. They said that they were supported by all staff on an informal basis. We saw that reflective practice sessions were planned and would be provided by a clinical psychologist.

Multi-disciplinary and inter-agency team work

- There were regular meetings taking place on the wards. We saw there was a regular referral meeting once a week where newly referred patients are discussed by the nursing and medical staff.
- A weekly medication review meeting took place every Tuesday and the three consultants held weekly review meetings.
- We observed that handover meetings discussed each patients in depth and effectively shared information their care. There were discussions about feedback from meetings, any changes in patients' overall presentation including physical health, section 17 leave, activities and incidents.
- There was evidence of working with the community forensic team. Staff told us that they worked closely with the community forensic team to coordinate care to support with discharges.

Adherence to the Mental Health Act (MHA) and Mental Health Act Code of Practice

- Records showed that consent to treatment requirements were not adhered to and attached to medication charts. We did not find a good system in place to ensure that consent had been obtained and recorded on the correct documentation. We looked at six patient T2 records and found that five of the six T2 forms we saw were not completed by the patient's current consultant.
- Most patients had their rights under the MHA explained to them on admission and routinely thereafter. However, one patient had only been given this once in 2014 and not since. Some patients' records stated that staff were unsure if the patient had understood. We did not see any audits to ensure that the MHA was being applied correctly.
- We looked at Section 17 leave forms and saw that they were completed, but with no expiry date entered in the relevant box and no review date was recorded. This meant that the responsible clinicians did not regularly review patients' short term leave.
- For patients detained under the MHA there were no outcomes recorded of how the leave had gone and the patient's view was not recorded. This could risk the safety of the patient and others when accessing leave from the hospital.

Are services effective?

Requires improvement

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

- Patients had access to the Independent Mental Health Advocacy service and staff were clear on how to support patients to access this. There were posters displayed on the unit about the IMHA service.

Good practice in applying the Mental Capacity Act

- Staff had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff did not demonstrate a good understanding of MCA and DoLS. The majority of staff felt they did not have any responsibility in MCA and did not know how the legislation applied to their work with patients.
- Staff were not aware of the policy on MCA and DoLS.
- A senior manager confirmed the trust did not train all staff in MCA and DoLS to provide them with knowledge required in applying the legislation appropriately. Most of the staff were not able to tell us who they would contact as the lead person on MCA within the trust.
- The use of the Mental Capacity Act was not monitored by the wards.

Good

Are services caring?

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

Summary of findings

We rated caring as **Good** because:

- Patients were positive about staff. We observed good interactions between staff and patients
- Staff showed that they knew about patients' needs and how they help them
- We saw that staff and patients eat together on Griffin ward
- Patients were introduced to the ward on admission
- Patients were involved in their ward reviews
- There was access to advocacy services
- Wards hold daily community meetings where patients can discuss concerns and choose activities for the day

However:

- Patients were not happy with the lack of privacy during visiting times
- Patients were not always involved in their ongoing care planning
- There was no regular auditing of patients views about the service

Our findings

Herschel Prins clinic

Kindness, dignity, respect and support

- Most of the patients were positive about the support they received from the staff and felt they got the help they needed. Patients told us and we saw that they had been treated with respect and dignity and staff were polite, friendly and willing to help. Patients told us that staff are nice and are interested in their wellbeing.
- We saw helpful interactions between staff and patients. Staff spoke to patients in a way that was encouraging, respectful, clear and simple and demonstrated positive commitment, and willingness to support patients.
- Staffs showed a good knowledge of the individuals' needs and were able to explain how they were supporting patients with a range of needs. Patients told us that staff knew them very well and supported them the way they wanted and made them felt safe.
- Staff and patients ate together on Griffin ward, which patients said they enjoyed doing.
- Patients told us they were not happy with the level of observation during family and friends visits which did not give them any privacy. Staff told us that they always supervise patient visits in the dining room.

The involvement of people in the care they receive

- The admission process informed and orientated the patient to the ward.
- Records did not always record the involvement of the patient in their care plan and evidenced that this was shared with the patient. Two said they had been consulted about their care plans and had been offered a copy.
- We observed that patients were involved in their ward round and were treated by all staff with dignity and respect. The patients we saw attend the ward round said they felt involved in their care.
- Patients had access to advocacy services. The advocate attended patient's review meetings where this was appropriate.
- Patients' families and carers were involved where this was appropriate.
- We were told that a regular audit of patients' views does not take place however the trust has introduced family and friends test. The clinic was unable to provide us with any data.
- There are daily meetings held on the wards. These meetings are attended by both patients and staff with a patient as chair. We observed two meetings and saw that all patients are encouraged to contribute by giving their opinion on planned activities for the day or about anything concerning them. On the days of inspection patients were concerned about the very strong smell of paint in the Phoenix ward.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

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

- A blanket restriction was in place about visiting as all visits had to be observed
- Patients did not have privacy during telephone calls because of the location of patient's phone
- On Phoenix ward the patients' kitchen did not have a fridge for patients to store goods that needed to be kept cool like milk
- Patients who had been on the wards for a long time complained that the menu was boring and repetitive.
- There was poor communication between the teams resulting in planned sessions having to be cancelled

However:

- There were regular meetings to discuss new referrals to the clinic
- All admissions were planned in advance
- Patients experienced a stable stay in the clinic with no movement of beds due to bed demand
- The location of the wards allow for people with a disability to access the wards without any difficulty
- Patients knew how to make a complaint

Our findings

Herschel Prins clinic

Access, discharge and bed management

- The unit had a referral meeting each week to discuss new referrals. The average length of stay was 18 months to 24 months. The referrals to Herschel Prins came from medium secure services, the psychiatric intensive care unit, (PICU), prisons, and patients moved back to Leicester from secure service.
- All admissions to the wards were planned in advance and they did not have any emergency admissions.
- The wards worked with the community forensic team to ensure that patients ready for discharge were helped through this transition.
- Patients experienced a stable stay during their admission period. The manager told us that all transfers were discussed in the referral meeting and were managed in a planned or co-ordinated way.
- We were told, and saw that two patients had delays being discharged because of difficulty finding them accommodation.

The ward optimises recovery, comfort and dignity

- The clinic was built and equipped to support treatment and care. There were lounges where patients could sit and watch TV or engage in therapeutic or leisure activities. The wards benefited from a quiet room, activity room, games room, lounge, activities of daily living kitchen, dining room, sitting area and a gym. There was also a secure courtyard with a football pitch.
- The location of the seclusion room was in the corridor leading to the patients' bedrooms. This protected patients' privacy and dignity.
- Visiting for up to two patients could take place in the shared dining room under observation by nurses.
- In both wards a patient telephone was situated in the corridor area and there was no privacy. The manager told us that patients used another telephone if privacy was needed. However, we saw patients talking on that phone whilst other patients were sitting nearby. Patients told us that there is no privacy with the phone as other patients could always overhear their conversations.
- The units had access to a secure garden area, which included a smoking area.
- Wards had kitchen areas where each patient was provided with a locked cupboard to store their food. There was no fridge and freezer for patients to store items that needed to be kept cold. Staff told us the fridge was condemned months ago and they had not had a replacement. We saw milk used by patients to make their drinks left out on the counter. Staff said the milk did not last long enough to turn sour.
- There was a varied response to the meal choices. Some patients told us that they were happy with the food and could have a choice of what they want from the menu. Others said the meals were repetitive especially when you have been on the wards for a long time.
- Patients had a range of activities available for them to participate in. The activities offered were not linked to their individual needs. We saw in the morning ward meeting that patients were told by staff what was on offer that day and were encouraged to participate.

Are services responsive to people's needs?

Requires improvement

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

- We saw a music group taking place in the shared dining room and the patients attending looked like they were really enjoying the session. They were singing and clapping enthusiastically. However the therapy programme for that day was anger management but that had to be cancelled because the music group was organised without discussion between the staff.

Meeting the needs of all people who use the service

- There were menus on display to keep patients informed about what meals they could have. The menus repeated every two weeks and had meals that met the religious and cultural needs of different patients. We saw that a choice of halal, kosher and Caribbean meals were offered. Patients had access to hot and cold drinks anytime during the day. There was some restriction at night but staff and patients said staff would make them drinks late at night.
- The wards were located on the ground floor and had full disabled access. Both wards had accessible bathrooms and toilets. All bedrooms with en-suite could accommodate patients with disability.
- There were information leaflets which were specific to the services provided and could be provided in different languages. Patients had access to relevant information such as patients' rights, advocacy, and how to make complaints.
- Interpreters were available to staff and were used to help assess patients' needs and explain their rights, care and treatment.
- Patients' individual needs were mostly met, including cultural, language and religious needs. Contact details for representatives from different faiths were on display in the clinic. Local faith representatives visited people on the ward and could be contacted to request a visit.

Listening to and learning from concerns and complaints

- Information on how to make a complaint was displayed on the boards including leaflets from the patient advice and liaison service (PALS). Patients could raise concerns in community meetings and we observed that they were resolved quickly in the meeting.
- Patients told us that they could raise complaints when they wanted to and they were listened to and given feedback. On patient told us they had made a complaint but nothing had changed. The manager told us and patients confirmed that they could approach staff anytime with their concerns and staff would try to resolve them informally and as quickly as possible. However, the units did not maintain records of informal complaints raised by patients.
- Staff were aware of the formal complaints process and knew how to support patients and their relatives to make a complaint following the trust's complaints policy or through PALS.
- Staff told us that any learning from complaints was shared with the staff team through emails, staff meetings and handovers.

Are services well-led?

Requires improvement

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

Summary of findings

We rated well-led as **requires improvement** because:

- Staff at ward level did not understand the vison and values of the trust
- The ward and organisation values were not set in practice
- The governance systems looked at quality and safety but had not addressed identified risks in the clinic
- Supervision when planned is not always delivered
- Qualified staff spend most of the shifts involved in office duties
- Staff reported bullying by other staff on the wards
- Some staff said forensic services felt lost and did not have a strategic direction
- Morale was described as variable across the clinic

However:

- Senior managers knew the vision and values of the trust.
- Immediate line managers were well known to staff.
- There were local forums that discussed aspects of care in the clinic.
- Matrons had autonomy to vary the staffing according to needs.
- Training was monitored to ensure staff were up to date with their statutory and mandatory training.

Our findings

Herschel Prins Clinic

Vision and values

- Senior leaders in the clinic were able to talk about the trust's visions and values however, ward based staff did not understand the vision and values of the organisation.
- Staff demonstrated an understanding of their ward objectives. However we identified that ward and organisational values were not set in practice. Practice did not completely reflect a person centred approach and positive risk taking as all visits were observed by staff.
- The majority of staff knew who their immediate senior managers were and told us that they visited the units.

Good governance

- The trust had governance processes in place to manage quality and safety. However, ligature risks had not been removed, repairs had not been carried out and there were blanket restrictions in place around visits on wards.
- The managers, psychologist, and occupational therapists attended local forums where aspects of quality and safety were discussed. The information was then discussed with staff and used to act on where there were gaps. For example, monitoring of mandatory training, staffing issues, incidents, and rolling 12 month appraisals.
- The managers felt they were given the authority to manage the units. They also said that, where they had concerns, they could raise them. Where appropriate the concerns could be placed on the trust's risk register.
- Supervision is provided inconsistently for staff, with planned supervision sessions been cancelled due to staffing levels not been consistent.
- Healthcare assistants spend much of their shift in direct care activities but qualified nurses were involved with administration tasks.
- Staff knew how to and reported incidents. There was feedback to staff on incidents and complaints through the email system and at handovers.
- Staff received training in MHA and MCA as part of their statutory and mandatory training however aspects of the MHA and MCA were not properly implemented on the wards.

Leadership, morale and staff engagement

- Managers were available on the units when care and treatment was provided. The managers were accessible to staff and provided them with support. Some staff told us that the managers were approachable, had an open door policy, and encouraged transparency. A few staff told us that they felt pressured to due to staffing issues and sometimes bullied by managers. Some staff on wards told us they were supported by their managers. We saw, and staff confirmed, that the teams were not cohesive with variable staff morale. However, the majority spoke positively about their role and demonstrated their dedication to providing high quality patient care

Are services well-led?

Requires improvement

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

- Some of the medical team felt they were not listened to and were side-lined. They said that the forensic services felt lost and that it was not clear where it was strategically. They felt the number of consultants was right although the vacancy had to be filled by a locum.
- Communication between services was poor and no clear contact between the wards and the senior management who attended governance meetings.
- Staff were kept up to date about developments in the trust through regular emails, newsletters and the managers shared information in the ward meetings and supervision meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Regulation 15 HSCA 2008 (Regulated activities) Regulations 2010** **Safety and suitability of premises** The provider had not ensured that patients were protected from the risks associated with unsafe or unsuitable premises by means of suitable design and layout. • Some wards had potential ligature points that had not been fully managed or mitigated. • Observation was not clear within the forensic wards. • Not all seclusion facilities had safe and appropriate environments. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 10 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Regulations 18 HSCA 2008 (Regulated activities) Regulations 2010** **Consent to care and treatment** The trust did not make appropriate arrangements to ensure the consent to care and treatment of all services users**.** • Not all patients had recorded assessments of capacity.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulations 9 HSCA 2008 (Regulated activities) Regulations 2010** **Care and welfare of service users** People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe. • Not all patients within the forensic and substance misuse services had a risk assessment in place. • Not all risk assessments and care plans were updated consistently in line with changes to patients' needs or risks. • Peoples' involvement in their care plans varied across the services. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Regulations 20 HSCA 2008 (Regulated activities) Regulations 2010** **Records**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23 HSCA 2008 (Regulated activities) Regulations 2010** The trust had not made suitable arrangements to ensure that staff were appropriately supported in relation to their responsibilities, including receiving appropriate training, professional development, supervision and appraisal. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
	The trust did not ensure that services users were protected against the risks of unsafe or inappropriate care and treatment through availability of accurate information and documents in relation to the care and treatment provided. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.