St Andrews Healthcare

St Andrews Healthcare - Nottinghamshire

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	Requires Improvement
Mental Health Act responsibilities	
Services for people with learning disabilities or autism	**Requires Improvement**

Summary of findings

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Summary of findings

Overall summary

There were systems and processes to monitor staffing, incidents and safeguarding, which were summarised in a ward dashboard. Up to date environmental audits and plans were not available on the wards. Resuscitation equipment was not checked on a weekly basis. We found staffing skill mix and deployment affected the patient experience. Patients were concerned about the turnover of medical staff. Staff and patients understood and applied the safeguarding processes well.

The hospital provided data for the first quarter of the year that showed almost one third of activities planned were not taken up by patients. However the patients we spoke with told us that there were not enough nurse led activities for them to do.

Thorsby ward had introduced the concept of a therapeutic community which was being embedded. There was an initiative called “meaningful conversations” which had been introduced to facilitate dialogue between nurses and patients which patients were positive about. There was a mixed picture about the way patients felt were treated by staff. We observed some staff to be caring and compassionate; we also observed one staff member swearing in the office and heard that there had been problems with staff attitude on Rufford ward.

There was an active patient representative group “our voice” who had formulated an action plan for changes that they felt were required.

We found that patients knew how to make complaints. Patients told us their complaints were rarely fully addressed and often do not receive clear responses. Out of 25 formal complaints only one had been fully upheld.

Patients did not consider that ward leaders were visible. Staff supervision was provided, however not consistently.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe? There were systems and processes to monitor staffing, incidents and safeguarding which were summarised in a ward dashboard. The environment was clean; however we found blind spots in the seclusion rooms and bedrooms. Up to date environmental audits and plans were not available on the wards. Resuscitation equipment was not checked on a weekly basis as required. Staff and patients were concerned about staffing levels. We found staffing skill mix and deployment affected the patient experience. Staff and patients understood and applied the safeguarding processes. Patients were concerned that feedback on the outcome took too long.	**Requires Improvement**
Are services effective? The hospital provided data for the first quarter of the year that showed almost one third of activities planned were not taken up by patients. However the patients we spoke with told us that there were not enough nurse led activities for them to do. Patients had well written risk assessments and care plans. Health action plans were implemented. Care programme approach meetings took place. We found there were good multi-disciplinary team meetings to review care which involved patients and analysed behaviours and incidents. National Institute of Health and Care Excellence (NICE) guidance informed policies, medication practice and psychological interventions. One ward had introduced the concept of a therapeutic community which was being embedded. Some patients had communication passports. There was an initiative called “meaningful conversations” which had been introduced to facilitate dialogue between nurses and patients which patients were positive about.	**Requires Improvement**
Are services caring? There was a mixed picture of the way patients felt were treated by staff. We observed some staff to be caring and compassionate; we also observed one staff member swearing in the office and heard	**Requires Improvement**

Summary of findings

that there had been some problems with staff attitude particularly in Rufford ward.. Not all patients felt their religious and spiritual needs were respected. Out of area placements posed difficulties for friends and families visiting and participating in specific meetings.

There was an active patient representative group "Our Voice" who had formulated an action plan for changes they required. Representatives from the group had participated in training and interviewing. Advocacy was available and used although requests for the service were not often made in relation to safeguarding issues.

Are services responsive to people's needs?

Good

We found that the service was responsive to patients' needs in general.

We reviewed case notes and found that discharge planning was included in care plans involving the person, family and agencies.

We observed that patients were able to personalise their bedrooms, on Thorsby ward they had also decorated the de-escalation room.

We found that patients knew how to complain and saw complaints leaflets on the wards. Staff knew the complaints process and resolved many complaints on the ward. We saw data that showed in the last twelve months there had been 25 formal complaints of which one was upheld and one partially upheld. Patients told us they were not satisfied with the complaints process. They felt their complaints were rarely fully addressed and often did not receive a clear response.

Are services well-led?

Requires Improvement

Patients who used services did not consider that ward leaders were visible. The staff were aware of the provider's board members, but were not clear about the provider's strategic direction.

The wards received key performance monitoring data to make improvements. Supervision was provided, however was not consistent.

We observed a reflective practice session which was led by a psychologist and this had been implemented to make improvements.

There was a high level of compliance with appraisals which were provided annually and mandatory training was monitored monthly in June it was 91%.

Summary of findings

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

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.

There were systems in place to scrutinise detention papers to make sure they followed the MHA and we found the detention papers appeared to be in order.

Patients were given their rights in relation to their detention every six months. We found no evidence of repeated attempts when patients refused or were unable to understand their rights. Patients had access to an Independent Mental Health Advocate (IMHA) and used them.

Case notes demonstrated and patients confirmed that hospital manager's hearings and mental health review tribunals took place.

We found some good documentation confirming mental capacity assessments in relation to medication and consent. However some of the records did not adhere to the MHA Code of Practice because they had not been completed by the current responsible clinician (RC).

In accordance with the Code of Practice Mental Health Act 1983 not all case notes confirmed that patients had been informed by the responsible clinician of the outcome of a SOAD nor had the statutory consultees recorded their discussion with the SOAD, this means that patients were not aware of the outcome of the independent review of their treatment plan.

Patients were granted section 17 leave. Patients, staff and records confirmed that this was not always facilitated. Internal leave in the hospital was recorded alongside external leave which is not in accordance with the Code of Practice. There was no record of patients being given copies of section 17 leave forms and patients said they had not received copies.

Seclusion rooms were on main corridors and had observation panels on the doors which were not covered, so limiting privacy. We observed a blind spot in the seclusion room which would necessitate the observing staff member moving from the observation room to the corridor.

We were informed by staff that patients were routinely searched when coming back from leave. The hospital needs to demonstrate they were adhering to the Code of Practice by ensuring that consent, and the rights of the individuals were explained and searches were proportionate to individualised risk.

We observed that staff had access to the copies of the Mental Health Act and Code of Practice.

Services for people with learning disabilities or autism

Requires Improvement

There were systems and processes to monitor staffing, incidents and safeguarding, which were summarised in a ward dashboard. Up to date environmental audits and plans were not available on the wards. Resuscitation equipment was not checked on a weekly basis. We found staffing skill mix and deployment affected the patient experience. Patients were concerned about the turnover of medical staff. Staff and patients understood and applied the safeguarding processes well.

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There was an active patient representative group “our voice” who had formulated an action plan for changes that they felt were required.

We found that patients knew how to make complaints. Patients told us their complaints were rarely fully addressed and often do not receive clear responses. Out of 25 formal complaints only one had been fully upheld.

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Summary of findings

What people who use the location say

A patient satisfaction survey was carried out in April 2014 by the hospital. 25% of respondents rated services in Nottingham as excellent, 60% between fair and very good and 15% as poor. The results for the hospital showed that staff made patients welcome on arrival to the ward. The wards were rated as amber overall, which meant over 75% of patients responding were satisfied in relation to being introduced to the ward and routines, food, cleanliness and noise at night. Patients felt that nurses listened to them carefully. The wards were rated as amber in relation to how other staff listened and treated patients with respect and dignity. 59% of patients spent between 30 to 90 minutes with their care coordinator, the remainder of patients did not know how much time was spent with their care coordinator. The hospital was rated as amber for care and treatment, however were rated red for activities. 93% of patients felt their spiritual needs were addressed.

Most patients told us there were some kind and helpful staff. All patients using services except for two told us there were too few staff to meet their needs. They told us this affected their experience, as it led to incidents, affected their ability to have section 17 leave, access to activities, privacy and dignity.

Not all patients knew who their named nurse was. There had been numerous changes in responsible clinicians and due to this high turnover patients did not feel comfortable.

Patients informed us that the food and portion sizes were not good; sometimes menus were misplaced causing confusion over dietary needs.

“Our Voice” patient representative’s focus group reported that ward managers were not visible and there were limited nurse led activities. The group stated that generally patients did not feel safe. Whilst patients understood the safeguarding process, they were frustrated by the length of time it took to receive the outcome of the safeguarding investigation.

There were mixed views about the effectiveness of the ward community meetings, some patient representatives reported that the meetings helped in discussing incidents in the context of a therapeutic community and others found the community meetings too dictatorial. The focus group reported that the “meaningful conversation “initiative was good.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is adequate skill mix and deployment of staff to meet the therapeutic needs of patients.
- The provider must ensure adherence to the Mental Health Act Code of Practice by ensuring current responsible clinicians document the mental capacity and consent to medication, document the outcome of Second Opinion Appointed Doctor (SOAD) reviews of treatment, and that statutory consultees record their discussion with the SOAD. Also by ensuring patients should be provided with a copy of their section 17 form and leave facilitated. Searches should take into account individual risk and consent.

Action the provider SHOULD take to improve

- The provider should ensure patients know who their named nurse and care coordinator is and regular meetings take place.
- The provider should ensure the ward leadership is visible to patients.
- The provider should ensure that there are no blind spots in the seclusion rooms and bedrooms.
- The provider should ensure that ward staff only use acceptable language and behaviours.
- The provider should ensure that patients are fully engaged in planned activities.

St Andrews Healthcare - Nottinghamshire

Detailed findings

Services we looked at:
Services for people with learning disabilities or autism.

Our inspection team

Our inspection team was led by:

Our inspection team was led by:

Chair: Stephen Firn, CEO, Oxlease NHS Trust

Team Leader: Nicolas Smith Head of Hospital Inspection Care Quality Commission

The team included CQC inspectors and a variety of specialists: Consultant psychiatrist, occupational therapist, mental health nurse, psychologist, and a mental health act reviewer.

Background to St Andrews Healthcare - Nottinghamshire

St Andrews Healthcare Nottinghamshire is a 66 bedded purpose built regional centre for men detained under the Mental Health Act (MHA). Patients admitted include those with a diagnosis of lower functioning autism and Asperger's syndrome; and have either established or suspected mild/borderline learning disabilities, who may present reactions to trauma and social deprivation. They may also have additional mental health needs, and a history of offending or challenging behaviour. Referrals are taken across the United Kingdom. The centre consists of four wards:-

Thorsby ward – a 14 bedded medium secure unit.

Wollerton ward – a 16 bedded medium secure unit.

Rufford ward – a 18 bedded low secure rehabilitation and recovery unit.

Newstead ward – a 16 bedded low secure assessment and treatment unit.

St Andrews Healthcare Nottinghamshire has been inspected seven times since registration and Mental Health Act monitoring visits have taken place.

We issued compliance action in January 2014. This was in relation to the hospital not ensuring there was enough staff to keep patients safe and maintain their health and welfare needs. This report also identifies concerns relating to staffing.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because they represented the variation in hospital care according to

Detailed findings

our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, <insert name> was considered to be a <insert risk level> service.

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?
- Is 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 and 10 September 2014. During the visit we :-

- Spoke to 25 patients.
- Reviewed 39 sets of care records.
- Reviewed medication charts.
- Observed a night staff handover to day staff.
- Observed a therapeutic community meeting.
- Observed a community meeting.
- Held a patients representative focus group.
- Held a social worker focus group.
- Spoke to staff including ward managers, consultants, professions allied to medicine, ward administrators, financial assistant, health care support workers, psychologists and occupational therapists.
- Reviewed documents ; policies, audits, ward data

Requires improvement

Services for people with learning disabilities or autism

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

Information about the service

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Requires improvement

Services for people with learning disabilities or autism

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Are services for people with learning disabilities or autism safe?

Requires improvement

Safe and clean ward environment

There were systems and processes to maintain a clean environment. The service user satisfaction survey in April 2014 rated the hospital as amber for cleanliness, this means over 75% of respondents were satisfied.

Generally the wards were clean. Bed linen was changed daily. There were hand washing information on the wards and access to hand washing fluid. There were daily cleaning rotas which had been completed. In the cleaning cupboard there were colour coded mops for use in certain areas. Furniture had been selected by patients and was clean and new.

Clinic rooms were fully equipped, clean and tidy with a weekly cleaning schedule that was up-to-date.

We looked at the resuscitation equipment and found that emergency drugs were in date. The emergency bag was scheduled to be checked weekly. We found that these checks had not been completed routinely.

Resuscitation equipment was shared between wards. We were informed that this did not delay its use.

We asked to see the current environmental/ligature audits. Newstead provided a fire risk audit and environmental action log dated November 2013 the information provided did not state if actions had been completed. Staff were not clear if these were the most recent versions.

We found that bedrooms had blind spots. Staff confirmed they would look through the window to observe or go into the room if the person was not in the bed. Showers were free of ligature points.

In the corridors there were breakout rooms, so staff would have to move around the ward to ensure patients were within their line of sight. Staff confirmed and we observed they did move around and checked on patients, those being at most risk were on frequent observations.

Seclusion rooms were on main corridors and had observation panels in the doors which were not covered, so limiting privacy. There were en suite facilities and

appropriate mattresses provided. We observed a blind spot in the seclusion rooms which would necessitate the observing staff member moving from the observation room to the corridor. The intercom on Newstead ward worked for the staff side only and the patient would have to knock on the window to gain attention. Clocks were positioned for the patient to see.

There was a pictorial contraband list for the medium and low secure units. There was a system in place which identified which staff were present in the hospital areas in the event of a fire. We observed a health and safety check being undertaken on a day to night shift hand over relating to drugs, cutlery, fridge temperatures and saw daily health and safety check lists on white boards in the wards that were completed.

There was a search policy and room searches were carried out monthly and randomly.

"Our voice" patients representatives and other patients stated that personal electrical equipment was tested on the Northampton site, this resulted in long delays before they could access some of their personal electrical equipment

Safe staffing

Ward managers had part time administration support available and reported that there were ward manager vacancies and absences at the time of our visit.

We found that the hospital relied on agency staff to deliver a great majority of the care and this affected the continuity of care and relationships. We were told that the wards providing leaning disability and autistic services could become unsettled if the staff team changed or consisted of several new staff at one time. Patients particularly with autism find inconsistences hard to deal with and may not feel safe. Some patients told us they did not feel safe.

The provider was aware that staffing is a problem and it was on the risk register. Active recruitment was taking place to fill vacancies. There was a standard operation procedure for reporting and governance of workforce issues identifying the responsibilities of each tier of management. The hospital had a set baseline of staff numbers, and we observed rotas where these were mainly met. We saw the ward dashboard which gave summative information about staffing, sickness, turnover and vacancies. We observed a daily hospital managers meeting in which staffing was reviewed across the hospital.

We were informed by managers that the hospital always worked to a staffing level of set numbers. 90% of the agency staff were known to the hospital as regular staff. We found that on many shifts there were more non-permanent staff working. Wards generally had two qualified staff on duty. Whilst the wards appeared to have appropriate numbers of staff the skill mix and deployment of these were of concern.

All but two patients highlighted their concerns about staffing and the impact this had on their experience. Examples given were cancellation of section 17 leave, lack of activities, incidents and lack of ground leave within hospital,

We found on Rufford ward that the ward manager was covering two wards and the staff nurse in charge was on their first day on duty. We found some agency staff on this ward did not know the needs of patients. Agency staff were not able to take patients on section 17 leave. This meant that permanent staff were often escorting patients whilst agency staff covered the ward areas

We found reference to staff shortages in several of the case notes we examined. For example on one file we found a note that a trip to a future placement, (part of a planned introduction) was postponed the day before it was due to take place as no driver was available. On another we found a record that the patient was concerned that staff shortage on Rufford ward had prevented activities taking place. No observations took place in the afternoon. The person reported that he "spent almost three hours in his room and wasn't checked at all.' A further note on a different day in August 2014 for the same patients stated that his mood fluctuated during the day from quite settled 'to becoming quite upset with regards to the staffing shortages throughout the day.'

Staff confirmed shortages of staff. For example we spoke to one member of the night staff. They told us that on some night shifts there was five agency staff working on the ward and this "can be scary, if no staff know the patients." We spoke to another member of staff, They told us the night shift staffing had consisted of one permanent qualified nurse, one permanent health care assistant, and five

agency staff members. We spoke with another member of staff who expressed concerns about the staffing levels on the ward. It was explained that the senior member of staff was usually in the office, which reduced the number of staff on the actual ward. Once staff breaks, escorts and 1 to 1 observations commence, the staffing levels were reduced further. This member of staff told us that they had recently supervised all the patients alone for two and a half hours. On the day of our inspection on Rufford ward, a member of staff was asked who was in charge; the response was "I don't know." It was reported that the pressure on the staff on the ward was "unbearable" and the behaviour of patients deteriorated due to the fact that there was not enough staff and their section 17 was cancelled. On the day of our inspection, there were a number of planned patient escorts. However one escort had already been cancelled due to the staffing situation.

During our visit to Rufford ward in the afternoon we asked the staff to provide us with a breakdown of the number of patients and staff on the ward. One patient required two members of staff to be with them. We saw that the two agency health care assistants were providing this level of support. Three remaining members of staff were providing care for the remaining patients. This included the nurse in charge, and two permanent health care assistants. We observed that the ward organisational noticeboard (which provides a breakdown of tasks the staff were to complete during the shift) was not completed from 1pm onwards.

Medical staffing had undergone changes due to rapid turnover and this was a concern to patients and carers. One patient said "I don't feel comfortable with so many changes of RC (responsible clinician). My life is in their hands".

Doctors on call were able to respond within 30 minutes out of hours. The consultants on call rota was shared with consultants who worked in Northampton and lived in the area local to Nottingham.

The occupational therapy team had staff on long term leave and were recruiting to vacancies. The occupational therapy team provided a seven day service and worked three evenings a week until 8pm. However when weekend work occurred then sessions were cancelled during the week. The psychology service had 6.2 whole time equivalent (WTE) psychologists for the whole site.

The pharmacy team consisted of one part time pharmacist two days a week and a pharmacist technician once every two weeks. They were supported by a pharmacist based at the Northampton location. However, the pharmacist was isolated from the other three service locations. There were no joint meetings to discuss, share and learn good practice for consistency with each other.

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 patient safety

Assessing and managing risk to patients and staff

We saw that each ward received a dashboard statement each month displaying the number of safeguarding alerts, incidents and complaints and staffing amongst other indicators. We were informed by staff that these are discussed in team meetings and handovers so that learning and action could take place. We observed a night staff handover and found the handover period was too short to discuss these; we looked at staff team minutes on Rufford ward and found no evidence of discussion.

We found in the majority of case records that risk assessments and plans were put in place on admission and updated. We reviewed case records and found that the HCR-20 violence risk assessment tools (this tool estimates a person's probability of violence) were being used. We found that HCR-20 assessments had been carried out soon after admission and repeated a year later. There was use of structured ratings demonstrating improvement and evidence of planning for discharge. Overall the ratings of risk via HCR-20 agreed with the data supplied and detailed enough to allow understanding of the relevant risk factors and their prevention and management.

There were exceptions. For example in one person's record we found no record of the HCR being completed soon after admission. Staff relied on earlier pre-admission information from 2011. Subsequently there was a single HCR-20 was provided however there were important aspects of details missing, capacity was not recorded even though the person had been identified as financially vulnerable. The fact that the patient preferred to speak to agency staff and ignore substantive staff was not regarded

a risk trigger. Our view was there was no clear formulation of the case in risk terms and the overall risk rating did not take into account a serious violent attack that had happened in May 2014.

There were policies and procedures in place for observation, searching and seclusion on the provider's intranet. We were informed by staff that patients are routinely searched when coming back from leave. The hospital needs to demonstrate they are adhering to the Mental Health At code of practice in ensuring that consent, rights are explained to patients and searches are proportionate to individualised risk.

We were told about the observation levels that operated on the ward. These included five, fifteen and thirty minutes checks, hourly checks, and increased levels of observations such as one member of staff to one patient, or two members of staff to one patient, and line of sight observations.

We were told of the procedure for managing aggression. When rapid-tranquillisation (the use of medication to calm the patient) was used, a registered nurse would observe the patient for a minimum of two hours.

On Rufford ward one person was seen to be on two to one observations when out of the bedroom due to the risk posed to others. Whilst in the bedroom he was not observed. The care plan stated the risks, rationale and clearly stated what the person needs to achieve to come off these observations. The patient had seen his care plan and inputted into it. Observations were reviewed by the multi-disciplinary team. We looked at the observational charts; during the day when on two to one observations these were recorded on counter fraud forms which went to the funding commissioner. Hourly observations were completed on a general form and then transferred into the electronic system. The ward was in the process of introducing tablet computers to record these observations so that they would be inputted straight onto the electronic system.

The hospital had a seclusion, extra care and longer term segregation policy dated June 2014 on the intranet and staff were aware of the policy, this was due to be reviewed in December 2014.

We checked a number of incidents involving the use of restraint and seclusion, and found that these were clearly documented. We found for the month of July 2014 that the longest time restraint was used on Thorsby ward for example was 10 minutes in one case and the rest were of much shorter duration and were classified as low to no harm. The longest seclusion period was for 17 hours

The ward dashboard reports on the number of seclusion and restraints and this are shared with the ward team. In the past year ;-

- Newstead had 115 incidents of seclusion in the past year, 390 incidents of restraint, of which 148, had been prone restraint, 16 resulted in rapid tranquilisation
- Rufford has had 15 incidents of seclusion, 43 incidents of restraint, 12, had been prone to restraint, 2 resulted in rapid tranquilisation and one person has been in long term segregation.
- Thorsby had 86 incidents of seclusion, 217 incidents of restraint, and 75 had been prone restraint, 15 resulted in rapid tranquilisation and two patients were in. 2 long term segregation.
- Wollaton has had 35 incidents of seclusion, 36 incidents of restraint, 11, have been prone restraint, 1 resulted in rapid tranquilisation.

We saw from the ward dashboard that the numbers of restraints and seclusion were being monitored and there had been a gradual reduction occurring.

Patients who recently experienced seclusion said that they did not find staff supportive. The medical staff confirmed they undertook seclusion reviews and that seclusion was used often and some patients benefited from being able to initiate it. Rapid tranquilisation was not used often.

We looked at the prevention and management of violence and aggression (PMVA) care plan audit carried out by the hospital in June 2014. This identified that not all details of patients preferred ways to be managed had been copied into the care plans, None contained patient debriefing and only 63% commented about what patients said about their experience. All patients had a PMVA care plan, and identified risk triggers and preferred de-escalation methods and observation levels.

Staff were trained in PMVA. At the night staff handover we heard staff discuss observing particular individuals who were following patients around in order to prevent any violence or aggression. One member of staff summarised that aggression was managed well on the wards stating "there's a good team" and "we try to actively engage the patients in therapeutic activities."

We observed in the daily hospital managers meeting that safeguarding alerts raised were discussed. Reviews of safeguarding alerts and concerns were undertaken weekly and there was monitoring by the local patient safety group. A safeguarding alert was tracked through and was correctly recorded in the patient's notes and incident forms. Some patients had safeguarding plans in place. Patients knew what a safeguarding alert was and what a safeguarding plan was. The patients' representatives on "our voice" stated that they were frustrated as they had to wait too long to be notified of the outcome of the safeguarding alert from the local safeguarding team. Also they did not consider it to be fair to have to remain on the same ward when the perpetrator was another patient.

Whilst there was a richness of data about patients care and treatment available, agency nurses could not access the electronic records and relied on "grab notes" which had printed out care plans and risk plans. We found that grab notes were not up to date or did not have information in them. This posed a clinical risk because agency nurses would not be familiar with the person's full history

Staff informed us that there had been no formal discussions about the Winterbourne View lessons and recommendations. There was a short document summarising restrictive practices arising out of Winterbourne View and what should be considered, that had been distributed to staff. Restrictive practices were discussed during supervision sessions and supervision records confirmed this. There were some blanket restrictions in place. These did not necessarily address individual needs. For example bedtime was 11pm, access to making hot drinks and smoking ceased from 11pm. Staff stated they would make hot drinks on request.

Reporting incidents and learning from when things go wrong

Incidents were reported electronically on the Datix system. The information was collated and looked at by the hospital safety group and the hospital quality and compliance group, and the information was cascaded to the provider wide governance groups. Wards received feedback on the number of incidents and trends. For example it was noted that more incidents occurred on a Sunday afternoon when there was a shift change over and on Tuesdays after the ward round, the ward responded by increasing staffing levels at these times. However we found generally staff were not able to describe recent learning from incidents across the organisation that had resulted in a change in practice.

We tracked through a number of incidents, restraint and seclusion incidents, these correlated with the case records.

The safety thermometer was carried out and results identified no issues relating to falls, urinary tract infections, venous thromboembolism, and pressure sores.

Serious untoward incidents were investigated and reported to the board, there was one serious incident on Thorsby ward for the period of May 2013 to June 2014.

We observed a meeting between the nurse coordinator, lead nurse, responsible clinician and other nurse managers that occurred daily Monday to Friday. This meeting discussed events from the previous evening and night such as incidents, seclusion, staffing, and a three day forward look at staffing. Overall this meeting profiled a swift accurate picture of relevant issues across the four wards with actions to be undertaken. However it was not immediately apparent who would have taken the relevant action.

Staff spoken with were aware of the bullying and harassment policy and whistleblowing policy. Staff confirmed they would feel at ease using these policies if required. However agency staff told us they did not feel confident to report.

There is a safeguarding policy on the hospital intranet. There were flow charts and telephone numbers visible on some of the wards. In the ward offices, the emergency telephone number, along with safeguarding information, was prominently displayed for staff to read. Staff spoken with were aware of the policy and was able to describe how they would recognise a safeguarding situation and what to do. Safeguarding referrals were discussed at each daily hospital managers meeting in the morning. We tracked through a safeguarding incident and found it had been appropriately managed. Safeguarding alerts were discussed at the multi-disciplinary team meetings.

51 staff members were injured between April 20015 and August 2014. Of these, four were reported under Riddor (reporting injuries, diseases a dangerous occurrence regulation 1985). Two were due to assaults by patients. We saw action plans in place to minimise staff injuries.

Requires improvement

Services for people with learning disabilities or autism

Understanding and management of foreseeable risks

We looked at the ward logs that showed staff had received mandatory training in fire, manual handling, hygiene, contraband, safeguarding, observation, and managing aggression.

Intermediate life support training and physical healthcare were merged into one training day; the hospital take up was above 50%.

Are services for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We looked at care records and found they contained up to date personalised holistic nursing care plans that were evaluated during multi-disciplinary team meetings. We saw that speech and language passports were used to aid communication with some patients.

On Newstead Ward we reviewed a third of all patients set of clinical notes. We saw comprehensive assessments, risk assessment, care planning and involvement of the multi-disciplinary team. The information was kept up to date and reflected the patient's current needs. In parts, some care plans were written in the first person. However we also saw a few examples of care plans that did not demonstrate an individual's involvement. We also saw clear documentation where patients did not wish to be involved in their care plan review and a note made of why the patient had not signed the care plan. We also saw the care plans that had not been signed by key workers.

We looked at case notes on wards and found 72 hour care plans for patients newly admitted, to address the immediate care needs. Following which a full care plan was developed. We saw that patients care plans contained information under the headings of where am I now, where do I want to get to, how do I get there, how will I know when I'm there, the timescales, and who will support me. The care plans covered need type, goals, interventions, progress, timescales and who was the lead healthcare professional assisting the patient. The care plan contained information relating to mental health recovery, stopping problem behaviours, risks, getting insight, making feasible plans, staying healthy, life skills and relationships. We saw some patients had signed their care plans to confirm that the care plan had been developed with them. We saw evidence that the care plans were reviewed on a monthly basis.

We did observe in one set of case notes that food and fluid balance charts were not completed as part of care plans, We drew this to the attention of the ward manager, who explained the that the patient was eating and drinking more than what had been recorded on the food and fluid chart. The patient had recently had some blood tests, and actions following the blood tests were clearly documented within the patient's care notes

Patients had had a care programme approach meeting. This meeting had been attended by the patient, psychiatrist, occupational therapist, social worker, assistant psychologist, senior social worker, behavioural team advisor, solicitor, named nurse and clinical administrator. This showed us that the full multi-disciplinary team were involved in the persons' care.

We reviewed case records and found that patients did have annual physical health checks. We were informed that recruitment was underway for an advanced nurse practitioner in physical health for the hospital. .

We found that patients had detailed health action plans which had been informed by a number of assessments. However we found one person who had epilepsy did not have a care plan in relation to this despite having a seizure in 2014.

The provider has a physical care action plan following an investigation on Grafton ward. This showed an amber rating for the Nottingham location. It showed that vital signs training were implemented in April 2013 for clinical staff. The updated action plan indicated that a full day intermediate life support refresher and physical healthcare training would be delivered. It showed the take up of training was low in Nottingham. An amber rating was given for medication training. The plan was reviewed and updated and a decision made not to use e learning for the majority of medication training apart from some specific training e.g. Insulin. The plan was to includes a one day course, completion of workbook, monitoring of competency by trained assessors and programme of

Services for people with learning disabilities or autism

additional medication training for identified high risk areas e.g. clozapine, controlled drugs. Competency would be checked within the probationary period for all new nursing staff.

We visited the GP consulting room and found it appropriately equipped. The GP was not currently visiting as the contract was out for tender. Patients confirmed they were registered with GPs. We reviewed case notes to look at the liaison between unit staff and the local GP and general hospital. We found the St Andrew's team maintained regular and appropriate contact with the local medical team in diagnosing and managing a complicated and serious medical condition. The healthcare nurse was on long term leave, Healthcare nurse cover was centralised and there was a senior nurse over Birmingham and Nottinghamshire sites with recruitment of an additional full time healthcare nurse.

A patient with diabetes explained his diabetic care plan and confirmed he has seen a dietician and a diabetic nurse specialist.

Best practice in treatment and care

Staff confirmed and we saw that clinical policies were based on best guidance and practice.

There was a medicines management group that met monthly to discuss NICE related guidance and issues. One consultant acted as a second opinion appointed doctor for the CQC. We were informed that a consultant had an interest in not medicating with anti-psychotic drugs for symptoms of autism and was monitoring this.

Appropriate arrangements were in place for recording the administration of medicines. Any concerns or advice about medicines were highlighted to the person's doctor by the pharmacist. The availability of a pharmacist on site helped to improve medicine safety.

Patients did not always receive their medicines promptly. Although a pharmacist was available part time there were no facilities to provide on-site dispensing of medicines. There was an emergency drug cupboard available which senior staff on site had access to. However, when medicines were not available on site then a courier system operated to collect medicines from the Northampton location which increased the time to obtain medicines.

An initiative called having "meaningful conversations" has been introduced by the provider for nurses to do daily with each patient, which patients told us was good.

Patients have some access to psychotherapy and Thorsby ward was run as a therapeutic community which meant that psychological therapy was the main approach to treatment.

The psychology services had carried out a psychological needs analysis for the four wards in relation to anti-social and offending behaviour, mental health and wellbeing, self-management and interpersonal skills, activities of daily living and noncompliance. The survey identified 75% of the hospital population required anger and anxiety management, motivation to engage, social relationships and skills, violence related intervention, planning skills, communication. We were provided with the programme of intervention summary for psychology and OT outlining the group aims and focus for each group. We observed a "keeping on topic in conversation" session led by a psychologist.

The psychology department said the Autistic Spectrum Disorder group was a useful adjunct to the organisation recognising the needs of autistic patient and organising training and therapy programmes for this group of patients. We observed an "autism group" session led by psychologists which was delivered with respect and the facilitator had a good rapport with the five patients in the group who participated throughout the session. The psychologist confirmed that NICE guidance was followed on the wards.

The wards had occupational and therapeutic activity programmes. Individuals also had their own activity programme for the week. There were mechanisms to capture the uptake of activities. The wards received a daily breakdown of the take up of activities. Staff confirmed that patients did not always take up what was offered. . Activities were discussed in community meetings

There was a social group based upon the model of creative ability assessment offered. However there was only one completed plan for sessions that the occupational therapist could show us. The therapists attended forums for national groups with the patients. Patients presented at these. Care plans with occupational therapist entries were missing. We were informed care plans were reviewed and updated accordingly with all member of MDT present

during the clinical reviews. There was confusion over who is responsible for the care plan when the name nurse and care co coordinator differed. The discussion regarding the care plan and content was not agreed in the MDT and left for the primary nurse to decide.

For evening activities a range of board games were purchased. The ward time table was limited to pool, cards and colouring. There is a reliance on the OT to lead and resistance from nursing staff to take over some of the activities that could be nurse led. The hospital reported nurse led activities did take place with individual patients which was recorded in the electronic patient records . Patients were supposed to receive individual timetables; however no patients on Newstead had received one in the week visited. Speech and language therapists (SALT) held a one hour group session weekly.

On the day of our inspection on Newstead ward we saw patients participating in activities, which included a session about "positive communication".

The majority of patients raised boredom and lack of activities as an issue. The hospital provided data that stated out of 36,634 hours of activity offered 10,413 hours had been taken up in one quarter. The spread sheet we saw gave reasons such as patients not attending, without specification of the reason for non attendance. There did not appear to be an understanding that if patients were opting out of sessions that there may be underlying reasons for that.

We did not find that staff participated actively in clinical audit or could name audits that had been undertaken and discussed. Staff were not aware of the research initiatives carried out by the provider.

Wards carried out the Essen climate evaluation schema questionnaire to measure the therapeutic climate of the ward. Wards generally had good scores and used the information to make improvements.

We reviewed case notes for outcome measures and found HoNOS (Health of the Nation Outcome Scales) was being used on a regular basis and provided detailed information about changes in a person's mental health status.

Skilled staff to deliver care

We saw records confirming agency staff received an induction to the hospital and to the ward. They were provided with mandatory training by their agency. Records and staff confirmed they had received a week long induction programme.

Staff confirmed that training was given to them in relation to autistic spectrum disorder, and more formalised sessions. There was also an autistic spectrum disorder specialist practitioner. There are no nurse prescribers at the hospital.

Mental Health Act, Mental Capacity Act and DoLS training was provided during induction training.

Staff and records confirmed annual appraisals were carried out. Clinical and managerial supervision was available however records identified this did not happen regularly.

The occupational therapy team provided a seven day service and worked three evenings a week until 8pm. Staff reported that when weekend work occurred then sessions were sometimes cancelled during the week. The timetables were updated weekly. The occupational therapist team decided what went on the activity programme; they decided which activities were most popular. Many patients preferred 1; 1 sessions which limit group activities. Educational courses were offered to patients. A healthy living group undertook activities of daily living, as well as 1:1 sessions.

Multi-disciplinary and inter-agency team work

We observed a multidisciplinary ward round on Newstead ward. It was attended by an acting consultant who had started work that week, a psychology assistant, occupational therapist, social worker, nurse and secretary. There was a large wall mounted screen displaying the electronic record and we observed there was good participation by all disciplines. We observed a good rapport with the patients and despite the formal layout of the room the patients appeared to be relaxed. Medication was discussed without it dominating over other approaches and therapies. There were innovative suggestions made. For example diary keeping to compare the patients' personal views with staff. There were individual considerations made such as pets visiting with family members. Racist and homophobic issues were discussed appropriately. Contact with families and section 17 leave were discussed. However many of the leave destinations appeared to be discussed near to the unit, so not

permitting full use of escorted and unescorted leave. Because of shortages of nurses few front line staff could attend the ward rounds and therefore missed out on the rich discussion relating to the treatment, care and management of individuals using the services.

We observed a night to day staff handover in which minimal handover of patient information was given relating to the patients, and highlighted behaviours that should be observed. The bulk of the information was provided by the health support worker who knew the patients. The handover did not provide time for discussion about care and risk plans. Agency nurses were expected to read notes during the night to catch up on the detail, however do not have access to the electronic notes.

We observed a multidisciplinary team ward meeting reviewing patients care and spoke to psychologists, and observed a group session led by psychologists and found that there was evidence of psychological therapies being used and an emphasis on relapse prevention.

Adherence to the MHA and the MHA Code of Practice

There were systems to scrutinise detention papers to make sure they followed the MHA and we found the detention papers appeared to be in order.

Patients were given their rights in relation to their detention every six months; However we found no evidence of repeated attempts when patients refused or were unable to understand their rights. Patients were knowledgeable about their right to an independent mental health advocate (IMHA).

Case notes demonstrated and patients confirmed that hospital managers hearings and mental health review tribunals occurred when they should.

We found some good documentation confirming capacity assessments in relation to medication and consent. However some of the records did not adhere to the MHA code of practice because they had not been completed by the current responsible clinician (RC).

Contrary to the MHA code of practice, not all case notes confirmed that patients had been informed by the responsible clinician of the outcome of a second opinion appointed doctors visit nor had the statutory consultees recorded their discussion with the SOAD. this meant that patients were not aware of the outcome of the independent review of their treatment plan.

Patients were granted Section 17 leave. Patients, staff and records confirmed that this was not always facilitated. Internal leave in the hospital was recorded alongside external leave which is not in accordance with the MHA code of practice. Some staff appeared confused about who could authorise leave. There was no record of patients being given copies of Section 17 leave forms and patients confirmed that they had not received copies. The outcome of leave was not always recorded and, when it was the patient views these were not always included.

We were informed by staff that patients are routinely searched when coming back from leave. The hospital needs to demonstrate they are adhering to the Mental Health Act code of practice in ensuring that consent and rights are explained to patients and searches are related to individual risk.

Staff had access to the Mental Health Act and code of practice. Legal advice was available when requested.

Good practice in applying the MCA

We found records of multi-disciplinary discussions about mental capacity in relation to holistic patient care. However we did not find evidence that these are recorded as best interest decisions. The advocate and social work team confirmed these discussions did take place. We did not find evidence of patients being supported by an independent mental capacity advocate but were assured that when patients do not have others to support them referrals are made.

Training in relation to MCA and DolS was provided upon induction, an example was given of a best interest's assessment meeting that was planned to take place.

Are services for people with learning disabilities or autism caring?

Requires improvement

Kindness, dignity and respect

On Thorsby ward the model of a therapeutic community had been introduced. Staff were passionate about using this model to develop a culture in which there was open discussion and challenge and promotion of responsibility between staff and patients using the services.

Requires improvement

Services for people with learning disabilities or autism

We spent some time observing the general interactions on Newstead ward. We saw that there was a good rapport between the patients and the staff. We heard respectful interactions from staff towards patients, and a relaxed atmosphere prevailed, with healthy banter.

On Rufford ward staff and patients told us, and we observed, some staff treat patients with respect. We also observed that a person who had touched a female member of staff in a jovial way was reprimanded in front of other staff and us. This could have been managed privately. However we heard from both staff and patients that some staff do not work well in the service. When we were on the ward we heard one staff member swearing in the office. We discussed this with the nurse in charge who agreed this was unacceptable and would be dealt with.

In relation to Rufford Ward we learned that patients had raised serious concerns about staff attitudes at community meetings. This prompted an investigation, which uncovered some unacceptable behaviour by staff in front of patients. We were told it has been referred to senior management. Patients gave us examples which included staff swearing at patients. Some staff told us they have raised concerns about the behaviour of other staff, and had been disappointed by the response of management. One said 'there are a lot of good staff who are not appreciated, but there are a lot of bad staff who are never criticised. We report and nothing happens.' One staff member told us they had witnessed a senior member of ward staff on Newstead, swear at a patient.

One patient told us he that had complained when a female staff member ignored him when he refused to 'hi 5' her, as he said it was contrary to his culture. This one patient said on another occasion he complained when a female member of staff refused him access to his toilet, when he badly needed to use it, as there were too few staff around and the dining hatch was open. He subsequently soiled himself and was embarrassed. He has complained to the hospital. We noted his PMVA care plan clearly records his wish not to be touched by female staff. He told us some staff makes fun of his religion. He said there is no Imam but this is not a problem for him as he is happy to talk to the Chaplin. Another patient told us that during Ramadan staff were dismissive of his fasting. He said halal food was provided, but was not always adequate and he had to microwave and provide it himself. He said he was unable to celebrate Eid as no Imam was available.

Not all patients we spoke to knew who their named nurse was. However records indicated that 1:1's did occur on a weekly basis for most patients.

The involvement of people in the care they receive

We observed a coffee morning in the café for charity manned by patients. We also saw a newsletter called "news of the wards" produced by patients for other patients.

A representative from "our voice" service user representative group had participated in developing a training video and had presented it at the providers training conference for nurses. Some patients had been involved in interviewing of staff for jobs. The provider prospectus for its recovery college offered work placements in Nottinghamshire; there were limited opportunities and take up for this.

The "our voice "service representative group have produced an action plan relating to the five CQC domains, and also participated in discussions about provider wide initiatives and policy.

There was information provided about advocacy on the wards including independent mental advocates. Advocacy visit the wards three days a week. Patients we spoke with knew who the advocate was and confirmed that they had used the advocacy services. Advocacy services reported that patients who had been subject to a safeguarding investigation often did not appear to know what the outcome was and what safety plans were in place. Advocacy were not made aware of any safeguarding meetings and patients were not always asked if advocacy support was required when safeguarding alerts were made.

We were informed by staff that patients were being encouraged to chair their own care programme approach (CPA) meetings. Patients reported this rarely happened and appeared to be dependent on the relevant RC.

We observed that c community meetings were held on wards and notes kept of the meetings.

"Our voice" patient representatives and patients we spoke with were concerned about being placed far away from their homes. Some had elderly parents who could not travel long distances. Where families could visit they were able to go the family room or café. Some patients had visits arranged to see their family. Staff told us that if relatives struggle with travel costs, the hospital would contribute up to £50 towards the cost.

Requires improvement

Services for people with learning disabilities or autism

We found staff responding positively to patients who experienced bereavement. During our visit a patient was being taken to another part of the country to attend a funeral, the person told us that this was the second time that he had been allowed to attend a funeral.

We saw that bedrooms were open and patients could choose to go to their rooms. There were also two or three lounges on each ward so that patients could have quiet time. There were de-escalation rooms that had been decorated by patients which were used only for de-escalation.

Patients had access to a phone box, located in a quiet position on each ward. They used call cards which they paid for. We were told that If they do not wish to use their call card credit to call the CQC, they have to ask staff to connect them. Some patients said this compromised their freedom to talk openly to the CQC. Patients could contact their advocate, without paying for the call, or involving staff, who could then contact the CQC on their behalf. We observed that both the advocacy phone number and the CQC phone numbers were visible in the phone booths.

Are services for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

Access, discharge and bed management

Patients receiving care at Nottingham are placed from anywhere in the country. Beds are always available on return from section 17 leave and patients are not moved from wards during an admission episode. The site did not have a psychiatric intensive care unit.

The length of stay from patients being admitted in 2008 to present ranged from 55 days to 2132 days. The mean bed occupancy was 89 – 100% across the wards. We looked at the data for referral to assessment and found these to be within the targets set which on average took five days. The data however showed there was variation in waits from assessment to treatment.

We looked at data for July 2014 which showed there had been two delayed discharges and no readmissions.

Patients were involved in planning their discharge from the point of admission. The effectiveness of treatment was reviewed regularly so that discharge plans could be implemented. Delayed discharge was seen as a service failure and investigated. Patients were discharged with a plan and patients were supported during transition.

We reviewed case notes and found that discharge planning was included in care plans. Overall we found good evidence of discharge planning between St Andrew's and other agencies. We saw evidence of involvement of the person and their family in the process. We met with the social work team and found they were proactive in keeping commissioners and community teams involved in order to minimise the risk of discharge and transfers being delayed. We spoke to patients who were being prepared for transfer along their clinical pathway, they had been involved in visiting their next placement and spoke positively about their move.

However we spoke to some patients who were not clear about what had to be achieved before discharge. One person who had a my shared pathway plan stated he did not know what was meant by the general term he would be discharged if showed "good behaviour".

Patients were supported to access health and social care services from other providers. There were agreed protocols and care pathways with acute services.

The ward environment optimises recovery, comfort and dignity

The hospital had a full range of rooms and equipment to support treatment and care. There were quiet areas on the ward and a room where patients can meet visitors. Patients were able to make phone calls in private. Patients had access to fresh air in outside spaces.

We saw the courtyard within the centre of the hospital was pleasant and well-maintained. Leading from the courtyard were the wards, the sports hall, music room, IT room with skype, video conferencing , a multi-faith room, activities of daily living kitchen, library, art and crafts room, café and GP surgery. Animals were brought in for patients to care for. We observed a dog and tortoise in the court yard being attended to by a patient.

Requires improvement

Services for people with learning disabilities or autism

On each of the wards we saw photographs of the staff team displayed. There was provision of accessible information on treatments, local services, patients' rights, how to complain in easy read format although it was not extensive.

Ward policies and procedures minimise restrictions

We observed that patients were able to personalise their bedrooms, on Thorsby ward they had also decorated the de-escalation room.

Patients on the wards could make hot drinks between 8am and 11pm after which staff would make drinks on request.

Meeting the needs of all people who use the service

Information leaflets were available on request in languages spoken by patients who use the service. There was also access to language line for interpreting services.

There was choice of food to meet dietary requirements of religious and ethnic groups, for example halal meals. Snacks were accessible during the day. Not all patients we spoke with were happy about the standard of food or the portion sizes.

Listening to and learning from concerns and complaints

We found that patients knew how to complain and saw complaints leaflets on the wards. Staff knew the complaints process and resolved many complaints on the ward. We saw data that showed in the last twelve months there had been 25 formal complaints of which one was upheld and one partially upheld.

Patients told us they were not satisfied with the complaints process. They felt that their complaints were rarely fully addressed and often did not receive a clear response. They reported that they chose to ask the advocate to raise their concerns directly with the hospital director, who did respond. Advocacy confirmed this and gave an example of a complaint raised in February on behalf of a number of patients across the hospital, When the complaint was followed up, the response was that the issue which related to food, had been resolved as the hospital has set up a food group. Patents had not been told this was in response to the complaint. Advocacy were concerned that when a complaint on behalf of a patient is raised, the hospital does not treat it as a formal complaint. Advocacy were in discussion with the hospital about this.

Are services for people with learning disabilities or autism well-led?

Requires improvement

Vision and values

Staff were not entirely sure of the organisation's values and strategy. Only Thorsby ward was able to show us its team objectives and had a clear vision for developing a therapeutic community. Staff know who the most senior managers in the organisation were and reported some visits had been undertaken by senior managers. The hospital manger was visible and it was evident that patients knew the hospital manager and had a good rapport. Patients informed us that they rarely saw the ward managers. Ward managers were described as being in the back office or in meetings.

Good governance

Ward managers had part time administration support available and reported that there were ward manager vacancies and absences at the time of our visit.

There were monitoring systems in place to demonstrate staff had received mandatory training and that staff were appraised. Supervision was provided although not consistently.

Shifts had a minimum number of core staff. However a majority of the staff were agency and outnumbered the permanent staff, agency staff did not know all ways know the detail of patients care.

Leadership, morale and staff engagement

A staff survey had been carried out and an action plan was in place

Staff were informed of the whistleblowing, bullying and harassment and grievance policies during their induction and the policies were available on the intranet. All staff apart from agency staff stated they would use the policies if required.

Staff had access to counselling services.

The ward dashboard reported on the monthly sickness and absence rates for staff for example there were seven days average sickness rates on Newstead ward in June 2014 and 12 in July 2014.

Staff meetings were set, however managers stated that it was a struggle to get staff released from wards to attend.

Staff had access to clinical and managerial supervision and a log of this was kept on the ward. The ward log on Rufford showed that supervision did not occur on a monthly basis.

We joined a reflective practice session which was chaired by a lead psychologist. The session occurs every three weeks. We heard discussions about the use of de-escalation and distraction. Further discussions took place about how the information from this session would be shared with other staff working within the ward. We heard that there was a nurses' forum which was due to start in October 2014 and an existing health care assistant forum. It was discussed that debriefs, following serious incidents, do not always happen, and this was being addressed. It was noted that bank staff were "generally aware" of how to manage situations on the ward through learning from the permanent members of staff, however they might not had had the opportunity to read the patients' care plans. There was discussion about attitudes and values, followed by the planning of the induction of a new responsible clinician to the ward

The pharmacy team were supported by a pharmacist based at the Northampton location. However, the pharmacist was isolated from the other three service locations. There were no joint meetings to discuss, share and learn good practice for consistency with each other. Promotional opportunities were reportedly good. However additional training to assist with promotional opportunities was limited. The member of staff would recommend the provider as a place to receive care or to be employed.

Commitment to quality improvement and innovation

Each ward had a monthly ward dashboard which provided key performance indicators to gauge performance in the areas of safety, effectiveness, care, responsiveness and leadership. Some wards were able to clearly identify improvements being made in seclusion and incidents.

The quality network for mental health services undertook a peer review audit in February 2014. St. Andrew's Nottingham met 92% of medium secure standards. The unit met 100% of the criteria in areas of, physical security, safeguarding children and visiting policy, clinical and cost effectiveness, accessible and responsive care, environment and amenities and public health. Areas such as serious and untoward incidents, handover process and support for carers were identified as areas in need of improvement.

Documentation audits were being carried out to ensure improvements in recording.

Staff were not able to say what research was happening in the provider and their involvement it.

There was a "principle of nursing practice group" which they were implementing and monitoring the principles of dignity, care, risk and communication, team work. This had not yet been evaluated.

Staff had appraisals in place and had interim appraisals meetings; we saw well completed forms, and found that staff was supported in their development. Staff stated and we saw that the provider provided a comprehensive induction programme.

Key performance indicators for mandatory training were collated monthly. These showed that nursing and medical staff had 100% achievement for basic life support and immediate live support and nursing and psychology staff had 100% for annual mandatory training. The remainder of the training groups were below the 90% threshold. Rufford and Wollerton were below 100% compliance and bureau staffs' compliance was low.

Agency staff received an induction from the agency and a local induction on the ward. Agency staff did not do a security induction. Agency staff are shown where the care plans are and advised to read these and the risk assessments. They do receive PMVA training and life support. Supervision is coordinated through the Northampton site, they are not offered clinical supervision and did not have whistle blowing or bullying and harassment discussed with them. They told us they would not feel comfortable following the whistleblowing process.

Staff can access line management courses, a Mary Seacole leadership course and shadow the ward manger. Continuous professional development is also supported by the organisation.

We saw the hospital's quality improvement plan displayed in the foyer. This provided information about patient safety,

patient experience and clinical effectiveness. We also saw information displayed about the 6 Cs, courage, care, communication, compassion, competence and commitment.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **How the regulation was not being met:** There was a lack of adherence to the Mental Health Code of Practice;- Patients using services had not been provided with a copy of their section 17 forms and leave facilitated. Blanket searches had occurred without take into account individual risk and consent. Regulation 9 (1)b (iii)

Regulated activity	Regulation
	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **How the regulation was not being met:** There was a lack of adherence to the Mental Health code of practice;- Current responsible clinicians had not documented the capacity and consent. Had not documented the outcome of SOAD reviews of treatment, statutory consultees had not recorded their discussion with the SOAD. Regulation 18

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **How the regulation was not being met**

This section is primarily information for the provider

Compliance actions

There was inadequate skill mix and deployment of staff to meet the therapeutic needs of patients.

Rufford ward had a ward manager covering two wards and the staff nurse in charge was on their first day on duty and did not know the ward very well.

There were more agency staff than permanent staff on many shifts.

Agency staff were not able to take patients on section 17 leave. This meant that permanent staff were often escorting patients whilst agency staff covered the ward areas.

Some agency staff on Rufford did not know the needs of patients. At one point during our visit on Rufford there were not enough staff.

Regulation 22