

# Avon and Wiltshire Mental Health Partnership NHS Trust

## Long stay/forensic/secure services

### Quality Report

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### Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Blackberry Hill Hospital	RVN3Q	Fromeside Medium Secure Unit	BS16 2EW
Blackberry Hill Hospital	RVN3Q	Wickham Low Secure Service	BS16 2EW
Trust Headquarters	RVN1H	FIND Community Service	BS16 2EW
Trust Headquarters	RVN1H	CJIT Community Service	BS16 2EW
Trust Headquarters	RVN1H	Pathfinder Community Services	BS16 2EW

This report describes our judgement of the quality of care provided within this core service by Avon and Wiltshire Mental Health 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.

# Summary of findings

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

### **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

The forensic and secure services are based in Blackberry Hill Hospital. They are purpose built facilities and provide inpatient mental health services for adults aged between 18 and 65.

Staff shortages on wards were widespread and were covered by taking staff from other wards. We were told bank staff did not want to work at Fromeside. Staff felt unsupported and concerned about the lack of experienced senior nurses on the wards. Senior managers, when asked, did not demonstrate a clear plan of how to support staff until a service redesign was implemented.

We found that this service did not focus enough on safety. Staff on the wards were not told about learning from serious incidents, and in general staff did not receive feedback about incidents they had reported. We found potential ligature points throughout the medium and low secure units and, despite these having been reported, these risks to people's safety had not been removed.

The provider had not checked that all medicines were stored at the correct temperature.

On Bradley Brook ward a compliance action had not been met regarding a corridor carpet that smelt of urine. There was no system in place to check this had been addressed.

While there were systems in place to record and report incidents and to assess risk, learning from incidents was not always implemented well at ward level. We found a number of risks to the service and the people who used it, such as ligature points, low staffing numbers, and a lack of experienced staff.

We found a lack of governance at ward level, which meant that the provider could not continually check the quality of services.

The care delivered by frontline staff was good. We saw that staff were caring, respectful and polite and patients confirmed this.

# Summary of findings

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

### Are services safe?

We found effective systems and evidence of learning on Wickham Low secure Unit, where new systems had been introduced following a serious incident.

However, services were not safe at Fromeside. While there were systems in place to record and report incidents, to assess risk and to discuss risk in the multi-disciplinary team meetings, learning from incidents was not always implemented well at ward or service level.

There was a shortage of staff and concerns about the lack of experience of staff in post. Four out of eight wards at Fromeside were without ward managers.

We had serious concerns about ligature risks throughout Fromeside, in particular bedrooms and bathrooms in the male acute service.

There was poor recording of fridge and clinic room temperatures. We also found out of date 'patient group directions' (guidance on who can be given certain medicines) and there was no list of staff who were able to administer these medicines.

### Are services effective?

At Fromeside we found a lack of experienced staff, particularly at ward manager and deputy ward manager level. There were general concerns with staffing levels being managed by taking staff from wards and moving them to work on unfamiliar wards. There was a good occupational therapy service, but not enough patients on the acute wards had access to it.

The multidisciplinary team had good involvement in care plan reviews and ward rounds. However, non-nursing staff (such as clinical psychologists and medical staff) did not spend enough time on most wards. The trust told us that a service redesign was underway which would aim to address these issues by Autumn 2014.

We found effective services at Wickham Low Secure and within the community forensic teams.

### Are services caring?

We found that frontline staff were caring across the secure inpatient and community forensic services. We saw that patients and staff interacted positively together, and found staff to be kind, respectful and professional. This was confirmed by patients who were positive about the care they received.

# Summary of findings

Patients were supported to maintain in contact with their families and facilities were available for visits from children. The trust had made Skype available for patients whose families could not visit. Families and carers were able to attend and contribute to care plan review meetings.

However, we found that the handbook for friends and families had not been updated for several years and much of the contact information was out of date.

There was a lack of consideration of the effect of loud music on some wards at Fromeside, and also the effect on patients of frequent false alarms going off.

## **Are services responsive to people's needs?**

Following a previous visit to Fromeside we had issued a compliance action regarding a corridor carpet. At this visit we found that this compliance action had not been met and the carpet smelt strongly.

There was a service user forum, but we were told that some involvement by people using the service was tokenistic as patients had not been consulted about the service redesign or the swapping of two wards.

Patients were not involved in the reviews that took place after people had been restrained or secluded in order to help improve staff practice in these areas.

The women's service and male complex care service at Fromeside provided individualised care tailored to the needs of the specific patient groups.

There was evidence across Fromeside and Wickham of good assessments before people went on leave.

## **Are services well-led?**

Services at Fromeside were not well-led; however leadership was better at Wickham and within community services. We found there was little connection between management at Fromeside and staff on the wards. Staff were nervous of raising issues as they worried this could get them into trouble.

We were concerned that staffing issues, and the worries of nursing staff about leadership and staff experience, had not been fully addressed by senior management.

There were no systems in place to identify why experienced staff were leaving the service and bank staff did not want to work at Fromeside. We were told this would be addressed in the service redesign in September 2014.

# Summary of findings

There was no system for responding to incidents at the unit, and learning from incidents that had occurred across the trust was not available to ward staff.

We found that a compliance action made following our previous inspection had not been met.



# Summary of findings

## Background to the service

The forensic and secure services are based in one hospital site at Blackberry Hill Hospital. They are purpose built facilities and provide inpatient mental health services for adults aged between 18 and 65.

### Services

- Medium Secure Service
- Low Secure Service
- Community Forensic Services

The trust has a total of 15 registered locations serving mental health and learning disability needs to people across Avon, Wiltshire, South Gloucestershire and Somerset.

Avon and Wiltshire Mental Health Partnership NHS Trust has been inspected 28 times since registration in April 2010. Out of these, there have been three inspections to Blackberry Hill Hospital.

The medium secure unit at Blackberry Hill Hospital was inspected in January 2012 when we took enforcement action on the provider's failure to ensure suitable staffing. Following this we found in March 2013 that the provider had taken steps to respond to this positively. In October 2013 we issued compliance actions for unsuitable premises and records. We followed up all of these actions at this inspection.

## Our inspection team

Our inspection team was led by:

**Chair:** Prof. Chris Thompson, Consultant Psychiatrist

**Team Leaders:** Julie Meikle, Head of Inspection  
Lyn Critchley, Inspection Manager

The team included CQC managers, inspection managers and inspectors and a variety of specialists including: consultant psychiatrists, specialist registrars, psychologists, registered nurses, occupational therapists, social workers, Mental Health Act reviewers, advocates, governance specialists and experts by experience.

## Why we carried out this inspection

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

## 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?

# Summary of findings

- 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 announced visits between 9 and 13 June 2014. During the visits we held focus groups with a range of staff who worked within the service, such as nurses, doctors,

therapists and allied staff. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We also carried out unannounced visits between 24 and 26 June 2014.

## What people who use the provider's services say

Patients told us that staff were caring and treated them with respect.

We were told that the staffing had improved before the inspection and patients had been able to go out on leave more. We were told that the occupational therapy service was good.

Patients on Teign ward told us they felt safe and cared for. Patients on one of the rehabilitation wards at Fromeside

told us they were sometimes concerned about the low numbers of staff, as they did not always feel safe. Patients commented that the frequency of alarms going off caused them to feel anxious.

Some patients said they were involved in the service users' forum; however patients at Wickham told us they felt they were not always listened to by the trust.

## Good practice

We found a good service being delivered on Teign Ward – the women's service. Staff worked within an integrated multi-disciplinary team with shared goals of improving

people's health and wellbeing. Nursing staff were supported by the psychology team to work within an 'attachment model' and could engage in training and reflective practice to implement this model effectively.

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

#### Action the provider **MUST** take to improve

- The trust must ensure that ligature and environmental risks are addressed and that effective risk management is in place until they can be removed.
- The trust must ensure that there are sufficient staff to safely meet the needs of patients and to support newly qualified or inexperienced staff
- The trust must ensure that all incidents are reported, investigated or learnt from and that learning from incidents is shared with staff at ward level and embedded in ward practices.
- The trust must ensure that the carpet in the bedroom corridor at Bradley Brook is replaced and that all flooring is appropriate and clean.

- The trust must ensure that the medication management and administration procedures are safe and effective and that checks are undertaken to ensure the integrity of medication.
- The trust must ensure that patients' views are sought and included in decisions about the environment and service delivery.
- The trust must ensure that governance arrangements lead to positive changes in practice.
- The trust must ensure leadership is improved and that there is effective communication between the 'triumvirate', senior managers and staff at ward level.

#### Action the provider **SHOULD** take to improve

- The trust should ensure that staff are trained to deliver effective supervision.

# Summary of findings

- The trust must ensure that information for patients and their relatives is accurate.

# Avon and Wiltshire Mental Health Partnership NHS Trust

## Long stay/forensic/secure services

### Detailed findings

#### Locations inspected

##### Name of service (e.g. ward/unit/team)

##### Name of CQC registered location

Fromeside Medium Secure Unit

- Teign
- Carey
- Ladden Brook
- Bradley Brook
- Avon
- Siston
- Kennett
- Wellow

Blackberry Hill Hospital

Wickham Low Secure Service

- Fairfax
- Hopton
- Cromwell

Blackberry Hill Hospital

FIND Community Service

Trust Headquarters

CJIT Community Service

Trust Headquarters

Pathfinder Community Services

Trust Headquarters

# Detailed findings

## 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.**

On all wards we found that there was good compliance with the Mental Health Act Code of Practice. Legal paperwork was in place. There was mostly good recording of patients' capacity and consent. However on Wellow ward we found that there was minimal information recorded for capacity assessments. An authority to treat was in place where required. However there was still room

for improvement for the recording of second opinion appointed doctors (SOAD) decisions. Some patients had not been informed of the outcome of the SOAD visit in respect of the decision taken.

All case files reviewed indicated that patients had been given their rights under section 132 in April 2014. However for most patients there had been a long gap since the previous discussion; for one patient that had last been done in October 2012.

We found that staff knowledge of the MHA was basic and limited to the essentials.

## Mental Capacity Act and Deprivation of Liberty Safeguards

All patients were currently detained under the Mental Health Act 1983 so we did not review the Mental Capacity Act or Deprivation of Liberty Safeguards.

# 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 found effective systems and evidence of learning on Wickham Low secure Unit, where new systems had been introduced following a serious incident.

However, services were not safe at Fromeside. While there were systems in place to record and report incidents, to assess risk and to discuss risk in the multi-disciplinary team meetings, learning from incidents was not always implemented well at ward or service level.

There was a shortage of staff and concerns about the lack of experience of staff in post. Four out of eight wards at Fromeside were without ward managers.

We had serious concerns about ligature risks throughout Fromeside, in particular bedrooms and bathrooms in the male acute service.

There was poor recording of fridge and clinic room temperatures. We also found out of date 'patient group directions' (guidance on who can be given certain medicines) and there was no list of staff who were able to administer these medicines.

importance of reporting incidents and the need for a strong reporting culture. There was information for staff on types of incidents reported which included violence, verbal abuse, injuries to staff and medication incidents. We noted that there was no reporting of numbers for incidents of self-harm by patients.

There was confusing information for staff in the rapid tranquilisation (RT) policy. It informed nurses that increased monitoring was needed following intramuscular administration of RT but did not mention procedures following oral medication. Our pharmacist found staff had not increased observations following administration of oral RT. The need for monitoring post oral RT was mentioned in appendix three of the policy but was confusing.

### Learning from incidents and improving safety standards

In the 18 months prior to our inspection there were three serious incidents. At Fromeside an absconcion had resulted in the raising of fences, installation of perimeter cameras and an alteration to some rooflines. Cromwell Ward on Wickham unit had carried out a review of all their procedures following a serious incident and staff described implementing a much more robust leave procedure. Incidents were discussed at team meetings on Fairfax and the ward had its own risk register.

A second serious incident at Fromeside had resulted in a coroner finding the trust neglectful. However staff we spoke with, including ward managers, were unable to tell us about any learning from this incident. We asked the secure services locality management team if information from this internal investigation and analysis had been shared with ward staff, in order to ensure learning and the reduction of risk in respect of similar incidents, and they told us it had not.

The provider did not always learn from incidents and share these across the trust. Three separate deaths by ligature had occurred at other adult inpatient services within the two months previous to our inspection. We asked staff at Fromeside, including a ward manager, if they knew about these incidents but they did not.

## Our findings

### Fromeside Medium Secure / Wickham Low Secure / Community Forensic Services

#### Track record on safety

There were systems in place to record patient safety incidents and allegations of abuse. Staff we spoke with knew how to report incidents but told us they did not always get feedback.

Where serious incidents had occurred we saw that investigations and a root-cause analysis were carried out. We noted, however, that one such analysis, at Fromeside, was not robust. Although the incident involved use of a ligature there had been no reference to the number of ligature points within the patient's bedroom.

We saw that an annual internal training publication was available for staff which discussed the importance of incident reporting. The publication explained the

# Are services safe?

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## **Reliable systems, processes and practices to keep people safe and safeguarding from abuse**

We observed good discussions about individual risk in multi-disciplinary team meetings. Every patient had a current risk assessment and we thought it good practice that their risk summary was highlighted in red on the electronic records system (RIO). We saw detailed risk assessments for patients which were easily accessible on RIO and we saw these contained patients' risk histories as well as current risks. There were also hard copies of risk assessments available. We were concerned, however, that one recently admitted patient who declared they planned to self-harm by ligature did not have a specific assessment and management plan for this risk. We found their bedroom and en-suite contained four separate fixed ligature points.

We found good recording and management of risk across Wickham low secure unit.

We were very concerned that on Ladden Brook and Bradley Brook at Fromeside every patient had a room with an ensuite bathroom which contained potential ligature points. There had been a previous incident where a patient had died from a ligature attached to the taps in their bathroom. We saw that every patient on the two acute wards in Fromeside had a bathroom with similar taps. In addition, the windows and window handles were potential ligature points as were some curtain rails which had not yet been replaced by anti-ligature rails.

A ligature audit was undertaken on Ladden Brook in March 2013 and the environmental risk assessment was added to the unit risk register. A follow up letter dated 18 October 2013 discussed the need for the fitting of anti-ligature taps and basins on both Bradley Brook and Ladden Brook wards. Replacement of shower controls and an anti-ligature bath were also recommended.

We saw copies of ligature audits carried out across Fromeside which identified risks which were to be either mitigated by limited by supervised access or staff observations of patients. We were concerned that the identified controls of staff observation and knowledge of patients, was compromised by the frequent movement of ward staff, use of agency and lack of experienced senior staff.

Staff told us that they had raised their concerns about ligature points on several occasions but that these had not

been addressed. We saw that peer reviewers from the Quality Network for Forensic Mental Health Services had raised the issue of potential ligature points in 2013 and the need for their removal or risk management.

At Fromeside we found that identified risks did not always have a management plan. We looked at the records for one patient at Fromeside who had repeatedly stated they were suicidal and had discussed using a ligature. This patient also had a history of impulsive behaviour. There was no assessment or risk management plan relating to how staff could ensure their safety in a room which contained ligature points.

Two patients on Ladden Brook told us they felt unsafe several times a week however this was not the case at Wickham low secure unit where patients confirmed they felt safe and supported.

## **Assessing and monitoring safety and risk**

The majority of staff we spoke with told us they were concerned about staffing levels at Fromeside. Staff said that the unit was 'haemorrhaging' staff and that experienced staff were leaving, which had left serious gaps in the ward structures. Patients also told us that there was a lack of staff and that staffing was inconsistent which meant they did not always feel safe.

We were concerned regarding the levels of staff, particularly qualified staff. Unit nurse in charge' (UNIC) records for Fromeside evidenced that there was an almost daily shortage of staff during May 2014. For the three months up to our inspection we found that the majority of shifts within this service identified staffing issues. The data showed that over the period there was a 31% shortfall of staffing below the numbers assessed by the trust as the safe baseline for secure services with 648 actual shifts filled of 938 planned shifts. Trust data also indicated that 14 incidents occurring in June 2014 were attributable to lack of staff.

We were also concerned that of eight wards on Fromeside, four were without a ward manager. Two wards were being covered by the modern matron who was due to retire the following month. A further two rehabilitation wards were covered by a single manager. Ladden Brook ward was on the point of losing both the ward manager and the 'band 6' nurse.

# Are services safe?

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

Senior management told us they had advertised for two ward managers and had recently recruited 20 'band 5' nurses. The majority of the nurses were newly qualified. The lack of experienced senior staff at ward level was raised with us repeatedly by staff we spoke with.

It was concerning that on Ladden Brook in particular, there will be a period of several weeks where there is little management support for staff due to both the ward manager and senior staff nurse leaving. We were told the ward would be managed by the modern matron for Wickham unit; however this is in addition to her role as matron. We were told by the managing director that five newly qualified nurses will take up posts on Ladden brook. It is of concern that potentially there will be no manager based on the ward to support the induction and training of these new staff.

We were concerned at the proportion of newly qualified staff in such a difficult and demanding environment where building relationships with patients is key to relational security.

There was poor recording of fridge and clinic room temperatures and this could potentially lead to the denaturing of drugs. We also found out of date 'patient group directions' (guidance on who can be given certain medicines) and there was no list of staff who were able to administer these medicines. Liquid medicines did not have the opening date which meant they could potentially be unsafe for patients.

## **Understanding and management of foreseeable risks**

While there was a plan in place for the longer term with the service redesign and the recruitment of 20 newly qualified nurses we found that there were no plans in place to cover the current shortfalls in staffing in particular the lack of experienced senior ward staff.



# Are services effective?

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

At Fromeside we found a lack of experienced staff, particularly at ward manager and deputy ward manager level. There were general concerns with staffing levels being managed by taking staff from wards and moving them to work on unfamiliar wards. There was a good occupational therapy service, but not enough patients on the acute wards had access to it.

The multidisciplinary team had good involvement in care plan reviews and ward rounds. However, non-nursing staff (such as clinical psychologists and medical staff) did not spend enough time on most wards. The trust told us that a service redesign was underway which would aim to address these issues by Autumn 2014.

We found effective services on Wickham Low Secure and within the community forensic teams.

Patients on Ladden Brook told us they were often bored on the ward as the nursing staff were stretched and occupational therapists were not yet based on the ward.

The FIND community team used best practice guidelines in their work with people with learning difficulties and autism. We saw that positive behaviour plans had been developed.

### Outcomes for people using the service

Fromeside was part of the Quality Network, the accreditation and benchmarking program run by the Royal College of Psychiatrists. This accreditation consists of self-assessment followed by peer review from staff working in other, similar, services. We saw the reports from May and September 2013. Recommendations from May 2013 were that the trust prioritises feedback from service users, improves carer involvement and ensures identified ligature risks are placed on a risk register or removed. The peer review report dated September 2013 found that patient focus and the environment and amenities were the areas most in need of improvement. The report stated, 'The matter of addressing the issue of removing ligature points [in bedroom and bathroom areas] as a matter of urgency is especially important given the recent history of serious incidents'. These recommendations had not been implemented.

We saw that the 'Safety Matters' newsletter used data from the National Reporting and Learning Service (NRLS) to inform staff that their reporting rate had increased and was now higher than average for mental health trusts. This evidenced that the trust had improved their rate of reporting against national benchmarks.

We saw evidence that outcomes for patients had improved as the length of inpatient stay in the medium secure unit had decreased. We spoke with community forensic nurses who described their role in supporting patients throughout their care pathway and on into the community. Community nurses told us that their support and liaison on behalf of patients had resulted in decreased re-admissions.

On Bradley Brook there was a serious incident which resulted from a needle-phobic patient being given medication by injection rather than in tablet form as recommended by staff who knew him. This resulted in a high level of aggression from the patient. The police were called and the patient was tasered. Had the patient's needs been taken into account this incident may have been prevented.

## Our findings

### Fromeside Medium Secure / Wickham Low Secure / Community Forensic Services

#### Assessment and delivery of care and treatment

Patients had an assessment of their physical needs on admission, and there was access to GP, nursing, podiatry and dental services within the hospital.

The trust did not always follow NICE guidelines on medicines. We found that the patient group directions were out of date and there was no list of nurses authorised to use them. We found that there were no care plans in place for the management of 'as required' (PRN) medicines to guide nursing staff.

On Kennett ward there was very good practice in identifying potential adverse drug reactions.

All patients had a care plan and risk assessment which we saw had been reviewed regularly however we did not see any care plans or risk assessments relating to ligature risks for individuals. There was reference within care plans to NICE guidance on violence and aggression and the warning signs however some of these plans had minimal detail.

# Are services effective?

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.

## Staff, equipment and facilities

We found that staff morale was poor. Staff told us that Fromeside was 'haemorrhaging' staff and that experienced staff leaving had left serious gaps in the ward structures. Nursing staff felt the service redesign was positive but were worried about the immediate future with poor staffing levels and staff regularly being borrowed by other wards to make up shortfalls. 'Unit nurse in charge' (UNIC) records for Fromeside evidenced that there was an almost daily shortage of staff. Often there would be a ward needing qualified nurse cover and on some occasions Ladden Brook and Bradley Brook would only have two or three regular members of staff on the ward. We were concerned that this impacted on the development and maintenance of effective therapeutic relationships between nursing staff and patients.

It was concerning that on Ladden Brook in particular, there will be a period of several weeks where there is little management support for staff due to both the ward manager and senior staff nurse leaving. We were told the ward would be managed by the modern matron for Wickham unit; however this is in addition to her role as matron. We were told by the managing director that five newly qualified nurses will take up posts on Ladden Brook. It is of concern that potentially there will be no manager based on the ward to support the induction and training of these new staff.

We were concerned at the proportion of newly qualified staff in such a difficult and demanding environment where building relationships with patients is key to relational security.

All staff received an induction on commencing employment at the hospital.

Some staff told us that there was no money available for training. Some staff had applied for funding for external training but had not received a reply.

However, training had been provided on Teign, Bradley Brook and Ladden Brook on 'RAID', a behavioural approach aimed at reducing challenging behaviours and encouraging positive behaviours amongst patients.

Staff on Teign Ward had been trained in attachment theory and worked within a multi-disciplinary team to deliver therapeutic interventions using this model. Specific

training had been developed by the psychologist attached to the ward to educate and support staff. Staff on this ward also had good supervision and there was a reflective practice group available.

Each ward had gym facilities which included a fitness bike. Access to exercise was encouraged by the hospital. We spoke with one patient who told us he used the gym equipment daily and he really enjoyed this.

We saw that the trust's IQ system reported that the majority of staff had received supervision within the last month. Staff we spoke with had mixed views of the quality of this supervision. Some staff said it was helpful while others said it was delivered by very inexperienced staff who just followed the pro-forma.

We were concerned to find that the bedroom corridor on Bradley Brook ward had a carpet which was stained, sticky in places, and smelt of stale urine. We asked the modern matron about this who told us the carpet always had a 'wet dog' smell when it had just been washed. We were told there were plans to replace the carpet. We also saw a further stained and dirty carpet in the bedroom in which a new patient was due to be placed and asked the ward manager to arrange for the carpet to be cleaned. The trust had been given a compliance action in respect of the carpet which had smelt of urine following the last inspection in October 2013.

## Multi-disciplinary working

We observed ward rounds and care program approach meetings and found that they were comprehensive and focused on outcomes for patients.

We found very good multi-disciplinary working on Teign ward where there was a whole team approach to providing patient care. Patients on Teign ward saw their consultant and psychologist regularly and were involved in the planning of their care.

There was poor day to day multi-disciplinary working on the male wards within Fromeside apart from Cary ward. Consultants, junior doctors and psychologists were based off the ward and wards did not have their own multi-disciplinary teams. This resulted in a sense of disconnection between nursing staff and other members of the team and resulted in a lack of effective team working. The trust was aware that there were poorer outcomes on these wards and a service redesign was due to be implemented which would base multi-disciplinary teams

# Are services effective?

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.

on the wards. However, at the time of our inspection this had not taken place and there was no interim plan in place. We did observe good multi-disciplinary working in the ward patient reviews.

We were concerned that the service redesign had resulted in reduced input from the psychology department. Psychologists told us that, as they were unsure if they would have jobs in the redesign, they felt it would be unethical to begin working with patients only to have the therapeutic relationship end abruptly.

We asked psychologists if they currently did short term work with patients such as coping skills and managing difficult emotions and they told us they did not. Currently they ran a dual diagnosis program and a DBT (dialectical behaviour therapy) group, however the DBT group was only for women.

At the time of our visit there was no group treatment program in place for violent offenders. Psychologists told us they had received training in the 'Violent Offenders Treatment Program' but did not currently deliver this to patients.

## **Mental Health Act (MHA)**

On all wards we found that there was good compliance with the Mental Health Act Code of Practice. Legal paperwork was in place and appeared lawful. There was mostly good recording of patients' capacity and consent. However on Wellow ward we found that there was minimal information recorded for capacity assessments. An authority to treat was in place where required. However there was still room for improvement for the recording of second opinion appointed doctors (SOAD) decisions. Some patients had not been informed of the outcome of the SOAD visit in respect of the decision taken.

All case files reviewed indicated that patients had been given their rights under section 132 in April 2014. However for most patients there had been a long gap since the previous discussion; for one patient that had last been done in October 2012.

We found that staff knowledge of the MHA was basic and limited to the essentials.

# Are services caring?

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

## Summary of findings

We found that frontline staff were caring across the secure inpatient and community services. We saw that patients and staff interacted positively together, and found staff to be kind, respectful and professional. This was confirmed by patients who were positive about the care they received.

Patients were supported to maintain in contact with their families and facilities were available for visits from children. The trust had made Skype available for patients whose families could not visit. Families and carers were able to attend and contribute to care plan review meetings.

However, we found that the handbook for friends and families had not been updated for several years and much of the contact information was out of date.

however we found that this had slipped and was no longer being implemented by staff. On Wellow ward we found that a patient was playing very loud music. This was not challenged or the impact on other patients considered.

On Teign ward we observed positive interactions between staff and the majority of patients told us they felt listened to.

Patients were positive about their experiences with staff and told us they felt cared for, respected and supported.

Across both Fromeside and Wickham we saw positive interactions between staff and patients.

### People using services involvement

We saw evidence that patients were involved in the management of their medicines and were able to speak with a pharmacist. On Teign there was evidence of good involvement of patients in their care plans, preferences were recorded and staff knew patients well.

Patients were supported to maintain contact with their families. There was a family visit room available for patients to see their children, if this was assessed as safe. There was a policy in place for this. Staff told us that they tried to obtain 24 hours' notice of a visit but would be flexible if somebody wanted to visit at short notice. On Teign ward women were supported to visit their families six weekly, a driver and either one or two staff would escort.

For patients who did not have leave or whose families were unable to visit the hospital provided Skype. This enabled patients to have more opportunity to maintain contact with important people in their life. We heard about one patient who had been able to use Skype to be involved in a relative's memorial service in America.

Patients had access to independent mental health advocates. Patients confirmed they had seen advocates.

### Emotional support for care and treatment

There was very good support for female patients on Teign ward and also for male patients on Cary the male complex needs ward.

We attended one patient's care review on Kennett which was attended by a relative who had the opportunity to ask questions and receive explanations.

One patient we spoke with said there could be more input from psychology to help cope with the stress of detention.

## Our findings

### Fromeside Medium Secure / Wickham Low Secure / Community Forensic Services

#### Kindness, dignity and respect

We found that the frontline nursing staff were very caring and committed to delivering the best care that they could. We observed that staff spoke to patients politely and with respect. For example we heard staff thanking one patient for letting them open their door to speak with them. During our inspection staff always asked patients' permission before showing us patients' individual bedrooms.

There was good involvement of patients in their care plan reviews on Ladden Brook, Teign and Wellow. Patients on wards at Wickham told us they were involved in planning their care and their views were listened to by staff.

Patients commented positively on the occupational therapy service. We observed one occupational therapy group discussion and found interactions to be kind, respectful and directed towards meeting patient need. On Cromwell we saw a multi-disciplinary meeting chaired by an occupational therapist which was kind, respectful and directed toward meeting the patient's needs.

One patient on Ladden Brook found loud music disturbing and a 'curfew' had been put in place to support this

# Are services caring?

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

Groups were delivered on all wards by occupational therapists and focused on themes such as cooking, gardening, motivation, drug and alcohol, CBT (cognitive behaviour therapy) and the gym.

The handbook available for families and friends of patients was several years out of date. We tried to contact the five staff named in the handbook and were told they had all left the organisation many years ago. We rang the helpline numbers listed at the back of the handbook and of 21 numbers provided only six were still current.

The carers group had not been running since last year and the voluntary sector organisation previously involved told us it was currently on hold. The Quality Network peer review had recommended in May 2013 that Fromside, 'consider developing a regular carer group', and to, 'create a directory of carer advocacy services'; however this had not been done.

# Are services responsive to people's needs?

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

## Summary of findings

We had issued a compliance action at Fromeside following a previous visit regarding a corridor carpet; however, this compliance action had not been met and the carpet smelt strongly on our visit.

The women's service and male complex care service at Fromeside provided individualised care tailored to the needs of the specific patient groups.

There was evidence across Fromeside and Wickham of good assessments before people went on leave.

There was a service user forum, but we were told that some involvement by people using the service was tokenistic as patients had not been consulted about the service redesign or the swapping of two wards.

Patients were not involved in the reviews that took place after people had been restrained or secluded in order to help improve staff practice in these areas.

### Right care at the right time

At the time of our visit two wards were swapping premises. This was to enable Fromeside to improve the beds available for patients, as there was a lack of enhanced rehabilitation beds and a need for fewer acute beds. We were told that the ward swap would enable patients to move more smoothly along their care pathways.

Avon ward was a rehabilitation ward in which patients have a great deal of access to the community. There were plans to move patients to Wickham unit more quickly to free up additional beds within the medium secure service.

We noted a potential of restrictive practice in the operation of the patients finance department. Patients' finance systems were confusing and patients had limited access to the cash office.

During our inspection we noted frequent false alarms from the personal alarm system used by staff. These alarms were loud and intrusive and resulted in staff reacting instantly. We were concerned that the frequency of these was unsettling for patients.

### Care Pathway

Patients on Wickham, Cary and Teign wards were involved in the development of their care plans and their views were sought. Care plans for other wards were more focused on managing violence than on recovery. Staff on Wellow felt there was not enough information for patients on what they needed to do to work towards discharge.

There was a café within Fromeside which offered patients vocational skills training in preparation for discharge.

The team on Cromwell ward were actively planning for discharge but were struggling to get the community mental health team to attend meetings. The consultant on this ward was actively involved in pushing for community treatment.

The FIND community team told us they were working to try to move people with a learning difficulty nearer home from out of area placements. However we were told that this team is to be disbanded under the service redesign. This team provided a range of interventions in locations that were accessible to service users.

### Learning from concerns and complaints

There was a patients' forum which met fortnightly where issues and concerns could be raised.

## Our findings

### Fromeside Medium Secure / Wickham Low Secure / Community Forensic Services Planning and delivering services

The women's service at Fromeside was a dedicated ward-based team which delivered a specific program for the needs of women patients. Cary ward worked specifically with patients with a learning disability or degree of cognitive impairment which was supported by the FIND team who provided specialist input. The ward ensured suitable adjustments had been made to ensure that posters, care plans and other materials were accessible for the client group.

Flexible services were offered by the occupational therapy department on individual wards, at the 'Malago' activities centre, and suitable community activities.

There was good physical healthcare within a dedicated area in the hospital. Patients could see a local GP or practice nurse as needed. There was access to podiatry and dentistry for all patients.



# Are services responsive to people's needs?

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

Community meetings were also held on wards but we found that these did not always happen.

We judged that some service user involvement was tokenistic. For example, one seclusion suite had dark blue covering on the walls. On entering the room we found it to be oppressive and claustrophobic. We asked staff about how patients felt about the room and one member of staff said, "They are just glad to get out of there". We asked the modern matron if they had asked patients how they felt about the colour of the room and they replied, "They are too unwell to tell us". We asked if any post seclusion reviews had been carried out or if patients had been asked to comment when they felt better. We were told they had not.

We asked the ward manager on Bradley Brook if they carried out post seclusion reviews with patients to find out how things could be done differently. He said there was no formal process. We did not see any records of post-seclusion reviews.

Patients on Fairfax and Cromwell wards told us that they did not feel listened to as they did not always receive feedback when they raised issues. Patients told us that they had not been involved in any part of the service redesign and nor had carers.

# Are services well-led?

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

Services at Fromeside were not well-led; however leadership was better at Wickham and within community services. We found there was little connection between management at Fromeside and staff on the wards. Staff were nervous of raising issues as they worried this could get them into trouble.

We were concerned that staffing issues, and the worries of nursing staff about leadership and staff experience, had not been fully addressed by senior management. There were no systems in place to identify why experienced staff were leaving the service and bank staff did not want to work at Fromeside. We were told this would be addressed in the service redesign in September 2014.

There was no system for responding to incidents at the unit, and learning from incidents that had occurred across the trust was not available to ward staff.

We found that a compliance action made following our previous inspection had not been met.

### Responsible governance

There was a trust-wide quality and performance system called 'Information for Quality' (IQ). This measures compliance with a range of measures including records, supervision and mandatory training, and managers are able to compare the performance of individual wards.

There was a skills training group on Ladden Brook, however there was no structured evaluation of its effectiveness. Staff were unable to describe how they ensured a quality service was being delivered and there was no evaluation of the service to determine what was effective.

We found that there were minimal systems in place for governance at ward level. Staff on one ward told us they were new in post and were so busy there had been no time to learn how to use the IQ system.

We fed back to the management team of Fromeside that staff had little knowledge of learning from the outcome of an investigation into the death on Ladden Brook and they confirmed that this was likely. There was no evidence that learning from this incident had been passed on to staff.

We were aware of recent incidents involving ligatures at other trust locations however this information had not been made widely available to ward staff to raise their awareness of similar risks at Fromeside or Wickham.

The trust had been given a compliance action following the last inspection at Fromeside in October 2013, in respect of a carpet which had smelt of urine. We asked the management team about the compliance action. They told us they believed they were compliant as the compliance action had been about a bedroom carpet which had been replaced, and this was a different carpet that smelt of urine. We found that that this matter had not been remedied and that systems had not been put in place to ensure compliance with this regulation.

Environmental checks for the bedroom corridor on Bradley Brook were carried out weekly however these were not effective and had not identified that the carpet in the bedroom corridor was stained and smelt very strongly. We had also identified this at our previous inspection and issued a compliance action which had not been met.

### Leadership and Culture

The community forensic teams had clear objectives and goals. Staff on Teign ward said they felt well supported by the multi-disciplinary team after involvement in incidents.

## Our findings

### Fromeside Medium Secure / Wickham Low Secure / Community Forensic Services

#### Vision and Strategy

We attended the trust-wide quality huddle, held fortnightly, where trust performance was discussed. While performance was discussed at board and senior management level, we found that this information had not reached staff at ward level who we found were stressed and demoralised.

Fromeside was undergoing a service redesign which was broadly supported by the majority of staff, although some staff thought it was carried out in an insensitive way. The redesign had looked at the model of the two wards that consistently performed well, Teign and Cary, and decided to implement this model across the hospital.



# Are services well-led?

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.

There was a lack of leadership at ward level on Fromeside as three of the eight wards did not have a ward manager in post. Ladden Brook was due to lose both their manager and 'band 6' nurse at the end of the week of our inspection.

Ladden Brook had two nurses on preceptorship and was about to employ a further five newly qualified nurses onto this ward. We asked the managing director about support for the newly qualified staff and were told that there would be support in place when multi-disciplinary teams were based on the ward. There was no plan in place to provide support in the interim.

The lack of ward managers meant there was poor day to day leadership on some wards. One member of staff said, "We can always ask the modern matron but he is so busy we don't like to". Staff told us that new staff did not get the on-ward training they needed because there was a lack of experienced staff to deliver this.

All the staff we spoke with raised concerns about lack of experienced staff on the wards. They told us experienced staff were leaving, and there was a lack of leadership at ward level. A common remark was, "We are haemorrhaging staff". We asked senior staff about this and they appeared unconcerned, replying that staff did leave and some had been promoted.

It was evident from the 'unit nurse in charge' reports that there were staffing issues on the majority of shifts. This did not appear to be monitored in a way that enabled managers to identify problems and develop longer term solutions. Staff told us that bank staff no longer wanted to work at Fromeside, which meant it was difficult to cover shifts. Managers had not investigated why so many experienced staff were leaving their jobs, why bank staff did not want to work at Fromeside and what could be done about this.

There was a lack of connection between what was happening at ward level, the perception of senior management and the understanding of risk at board level. When we asked senior managers about their concerns they did not mention either ligature risks, the high levels of experienced staff leaving, and the lack of experienced leadership on some wards. These were the main issues raised by staff at ward level.

Ward managers were not represented on the service-level groups such as the 'improvements group'. Staff told us that the IQ system felt like 'big brother watching' and was perceived as a performance management tool.

We were told that morale was very poor and that a number of experienced and highly qualified staff had either left or were planning to leave the organisation. Other staff told us that they had not felt involved in the service redesign and did not feel listened to.

## Engagement

At Fromeside we found there was no local leadership response to issues of concern raised by staff.

We spoke with staff who told us that they had regularly raised concerns about ligature points on Fromeside but had not received a response from the management team. No action had been taken and there were no risk management plans in place. We saw that ligature audits had taken place but these had not been used to generate a coherent plan for managing ligature risks.

Fromeside was undergoing the switching of two wards. There was no evidence that service users had been consulted or involved in any discussions about the redesign or changes to the environment. Patients had not been informed and builders had 'just turned up'. While there was a service users' forum in operation we found that there was little evidence of service user involvement in the running of the hospital and little or no consultation and involvement of carers.

## Performance Improvement

At Fromeside we saw that in response to one serious incident effective action had been taken and improvements made in the physical security of the building. However, in response to a second serious incident caused by a ligature, no systemic action had been taken and we found that improvements and learning had not been implemented at ward level.

A ligature audit was undertaken on Ladden Brook in March 2013 and the environmental risk assessment was added to the unit risk register. A follow up letter dated 18 October 2013 discussed the need for the fitting of anti-ligature taps and basins on both Bradley Brook and Ladden Brook wards. Replacement of shower controls and an anti-ligature bath were also recommended.

# Are services well-led?

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.

We saw copies of ligature audits carried out across Fromside which identified that risks should be either mitigated or limited by supervised access or staff observations of patients. We were concerned that the

controls indicated such as staff observation and knowledge of patients were compromised by the frequent movement of ward staff, use of agency and lack of experienced senior staff.

# 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

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

Transport services, triage and medical advice provided remotely

### Regulation

The registered person had not protected service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines:

How the Regulation was not being met:

- On a number of units we found that temperature checks necessary for ensuring the integrity of medications had not been undertaken
- We found out of date 'patient group directions' and there was no list of staff who were able to administer these medicines
- Liquid medicines did not have the opening date which meant they could potentially be unsafe for patients.

Regulation 13

### Regulated activity

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

Treatment of disease, disorder or injury

### Regulation

The registered person had not ensured that as far as reasonably practicable there were suitable arrangements to ensure the dignity, privacy and independence of service users and that service users are enabled to make, or participate in making, decisions relating to their care or treatment.

How the Regulation was not being met:

- Not all patients were involved in the planning of their care and treatment

Regulation 17—(1)

# Enforcement 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

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

Treatment of disease, disorder or injury

### Regulation

**The provider had not ensured that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises**

**How the Regulation was not being met:**

- On a number of wards we found potential ligature risks that had not been effectively mitigated or managed
- The trust has failed to have regard to reports prepared by CQC relating to their compliance following a CQC visit to Blackberry Hill in October 2013 as on Bradley Brooks we found that the carpet smelt strongly of urine

**Regulation 15(1)**

### Regulated activity

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

Treatment of disease, disorder or injury

### Regulation

**The provider had not safeguarded the health, safety and welfare of service users by taking appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity:**

**How the Regulation was not being met:**

- A number of units were experiencing significant staff shortages which may have impacted on patient care and safety.
- Supervision arrangements for new staff were insufficient
- Management arrangements were insufficient

**Regulation 22**