Care Quality Commission

Oxleas NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RPGAB	Bracton Medium Secure Unit	Danson Heath Joydens Crofton Birchwood Burgess	DA2 7AF
RPGXA	Greenwood and Hazelwood	Greenwood Hazelwood	SE18 3RZ

This report describes our judgement of the quality of care provided within this core service by Oxleas NHS Foundation 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 Oxleas NHS Foundation Trust and these are brought together to inform our overall judgement of Oxleas NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated forensic inpatient services as requires improvement overall because:

- Only two staff were allocated to work on Birchwood. Staff told us one member of staff would often work alone on the ward if the other member of staff was facilitating patient leaves. The service implemented a lone working policy and staff used this. Sanctioning lone working on a secure inpatient ward risked the safety of staff.
- All wards had potential ligature risks in communal patient areas, including areas where patients had unsupervised access such as an unlocked laundry room on Heath. Trust policy did not require staff to assess for ligatures in all areas of the ward environment.
- The service had a banned item list, which included plastic bags. However, there were plastic bags in all areas of the wards, including areas where patients had unsupervised access such as bathrooms and laundry rooms. Plastic bags posed a risk to patients and staff.
- The seclusion room on Heath did not meet the guidance set down by the Mental Health Act Code of Practice (2015). There were a number of instances when staff did not routinely advise patients of their rights under section 132 of the Mental Health Act and some patients did not have robust capacity assessments in place to confirm they were able to understand and consent to their treatment. Staff did not routinely complete training and updates on the Mental Health Act Code of Practice (2015).
- It was difficult for staff to demonstrate links between when they carried out the ward based ligature audit and when the work to remove or modify risks had taken place. Although, the trust was able to evidence how actions arising from ligature audits were logged, managed and actioned.

However:

- Staff managed risk well and patients told us that the service felt safe. Staff undertook thorough risk assessments for each patient. They were trained in safeguarding adults and safeguarding children procedures. They reported concerns to the local authority when they needed to.
- Staff knew how to report incidents and managers investigated them; and then shared lessons learnt with staff. The service had safe systems to manage medication. There was an on going recruitment programme to fill vacancies and managers had succeeded in recruiting to all nursing vacancies at the time of the inspection.
- The wards provided comfortable, safe, modern and suitable facilities for patients. There were secure door entry systems to prevent unwanted visitors and to manage the security level of the environment.
- Staff provided high quality treatment and care. Different professionals worked well together to assess and plan for the needs of patients. Patients had up-to-date risk assessments and care plans. These focused on treatment plans, recovery and rehabilitation. Staff used specialist tools to assess the needs of patients. Staff routinely supported patients to deal with their physical health needs and developed service-wide initiatives to strengthen this, such as the Food Strategy and the Wellbeing Strategy. Patients could access smoking cessation and drug awareness support.
- To aid their recovery, patients had access to a wide range of specialist psychology and occupational therapy led therapies. These included art therapy, judo, relaxation, anger management, family therapy and a sex offender’s treatment programme. The service provided patients with access to a wide range of sports activities such as basketball, hockey, swimming and a gym. Patients also had access to fun activities, which included shopping trips, B-B-Qs, trips to the seaside, and trips to local places of interest.
- Staff ensured patients were fully engaged with their treatment programmes and patients were involved in developing their care plans. The service routinely sought patient and staff feedback. They made

Summary of findings

changes to the way they did things based on this feedback. There was a strong culture of involving patients in the running of the service and patient's views were taken seriously.

- The service invested in, and was responsive to the needs of, its staff. As a result, staff morale was good. Managers listened to staff and provided them with additional resources when they asked for them. Managers routinely held supervision and annual performance reviews with staff and these were up-to-date. Staff had mandatory training, which managers monitored to ensure compliance. Managers supported staff to develop their skills and career by funding external and specialist courses.
- The service was well led at a local level and managers had good systems in place so they could audit the quality of care. However, senior managers in the trust did not demonstrate that they had sufficient oversight of some audits to determine if they were effective. Ward managers were accessible to their staff. They demonstrated the skills and experience needed to improve the service for patients. Managers and staff were continually looking for ways to improve clinical outcomes for their patients. They encouraged staff to undertake project and research work.
- The service was part of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services and carried out both self and peer reviews with the network.

Summary of findings

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

Are services safe?

We rated safe as requires improvement for forensic inpatient services because:

Requires improvement

- Only two staff were allocated to work on Birchwood. A lone working policy was in operation but staff lone working on a secure inpatient ward risked the safety of staff and patients.
- All wards had potential ligature risks in communal patient areas, including areas where patients had unsupervised access such as an unlocked laundry room on Heath. Trust policy did not require staff to assess for ligatures in all areas of the ward environment.
- The service had a banned item list, which included plastic bags. However, there were plastic bags in all areas of the wards, including areas where patients had unsupervised access such as bathrooms and laundry rooms. These posed a risk to staff and patients but the risk had not been identified on the trust risk register.

However:

- Staff knew how to protect patients from avoidable harm.
- Staff carried out appropriate risk assessments to keep patients safe.
- Staff completed their mandatory training and managers monitored their attendance to ensure compliance. Training compliance rates were high.
- The unit had the correct medication management policies in place and pharmacy carried out regular medication audits.
- Staff knew how to report incidents or risks of harm. Staff logged incidents and managers investigated them. Staff used team meetings to share information about incidents so they could learn lessons from anything that had gone wrong.
- The units were visibly clean, clutter free and well maintained.
- The service had policies for protecting patients and staff understood how to recognise and report safeguarding concerns.

Are services effective?

We rated effective as requires improvement for forensic inpatient services because:

Requires improvement

- The seclusion room on Heath did not meet the guidance set down by the Mental Health Act Code of Practice (2015).

Summary of findings

- There were a number of instances when staff did not routinely advise patients of their rights under section 132 of the Mental Health Act.
- In five out of six cases we looked at, patients did not have robust capacity assessments in place to confirm they were able to understand and consent to their treatment.
- Following changes in the use and purpose of Joydens and Heath, some female patients were waiting to be assessed to determine which level of security would best meet their needs.
- Records did not indicate that patients were routinely given a copy of their section 17 leave form

However:

- Staff planned and delivered patient care and treatment in line with current guidelines, such as those from the Royal College of Psychiatrists and the National Institute for Health and Care Excellence (NICE).
- In line with NICE guidelines and the Mental Health Act Code of Practice (2015), patients received thorough physical health checks and medical support to promote their wellbeing. Patients had access to a psychiatrist and a GP.
- Staff assessed and treated patients in a timely manner.
- The service had the capacity to screen patients for learning disabilities and autistic spectrum disorders to ensure they received the right support. They employed a physical health nurse and trained healthcare assistants in phlebotomy.
- Care plans were up-to-date, showed patient involvement, and staff regularly reviewed them.
- Staff developed detailed therapy programmes, which gradually increased patients' independence so, as they got better, they could become more independent and move on from the service.
- Psychological therapies, such as cognitive behavioural therapy (CBT), art therapy and family therapy were readily available and patients accessed them.
- The unit provided a full multidisciplinary service by employing a range of professionals to meet the needs of all their patients.
- Staff stored Mental Health Act legal paperwork securely and could access it easily.
- Patients had access to third tier mental health review tribunals, managers' hearings, and mental health advocacy.

Are services caring?
We rated caring as good for forensic inpatient services because:

Good

Summary of findings

- Staff involved patients as real partners in their care, treatment and rehabilitation.
- Staff supported patients kindly and treated them with dignity and respect.
- We observed many kind, meaningful and caring interactions between staff and their patients.
- Staff responded quickly and compassionately to their patients.
- Patients were encouraged to develop their independence. Staff supported them to manage their mental health, their physical health and their emotional needs.
- Patients understood their care plans and were fully involved in developing them.
- Patients were meaningfully and actively engaged in the running of the service.
- There was access to an independent mental health advocacy service that was easy for patients to use.

Are services responsive to people's needs?
We rated responsive as good for forensic inpatient services because:

Good

- Staff assessed patients for the service in a speedy and timely manner. They kept patients, and referrers informed about the referral and assessment process and developed relationships with patients before they arrived on the wards.
- The unit supported patients to achieve their goals and develop a better understanding of their needs.
- The pathway toward discharge was transparent and clear for patients and their families to understand.
- Patients could access the right care at the right time because they had a range of professionals available to support them.
- The wards provided a modern and comfortable environment with access to useful outdoor spaces.
- Staff worked closely with patients to ensure they could develop skills that would help them in their lives, beyond being an inpatient. They provided real work and voluntary work opportunities.
- Patients knew how to make complaints and there were meaningful opportunities for them to provide feedback about the service.

Are services well-led?
We rated well led as requires improvement for forensic inpatient services because:

Requires improvement

Summary of findings

- Risks within this service had not been addressed effectively by the trust. For example, staff could not demonstrate links between when they carried out the ward based ligature audit and when the work to remove or modify risks had taken place.
- There were gaps in translating audit findings into actions taken at ward level.
- The trust had failed to take action in a prompt manner to address the concerns which had been highlighted to them by local ward managers.
- Local leaders had not promoted sufficient grip or pace to bring about changes where necessary in a manner that showed patients and staff that there was any urgency about improvements. Changes took a long time to implement within this service.

However:

- Managers led the ward teams well and the appointment of new staff had strengthened the teams. Staff and managers showed a commitment towards continual improvement and innovation at ward level. They were proud of their service and keen to showcase their success.
- The service was responsive to feedback from patients and staff. Based on the feedback they received, staff looked for ways to improve how they did things.
- Staff were confident they could speak up if they had concerns and felt their managers would listen and support them. Several staff told us the service was the best place they had worked and compared most favourably with previous jobs. Morale amongst staff was good.
- Local managers were visible and available to staff and patients.
- The service was part of the Royal College of Psychiatrists' quality network for forensic mental health services and carried out both self and peer reviews with the network.

Summary of findings

Information about the service

Oxleas NHS Foundation Trust forensic inpatient services were located on two hospital sites: The Bracton Centre in Dartford and Memorial Hospital in Greenwich provided low and medium secure care for patients. 'Low secure' and 'medium secure' are the terms used for mental health wards where patients are compulsorily detained to receive care and treatment under the Mental Health Act 1983. The Bracton Centre had six inpatient wards and Memorial Hospital had two.

The Bracton Centre provided a range of specialist forensic mental health services for people aged 18 - 65 living in the boroughs of Bromley, Bexley, Greenwich and Lewisham as well as other boroughs when requested. The centre offers assessment, treatment and rehabilitation across six wards. There are four male and two female wards.

Burgess and Crofton Clinics were both 16 bed units within a medium secure setting for assessment and treatment of men. Danson Clinic was an18 bed unit within a medium secure setting which provides a rehabilitation service for men with longer term needs. One bed on Danson was kept as an emergency bed, for patients who may require urgent transfer or recall by the Ministry of Justice.

Birchwood provided a pre-discharge service for 13 men in semi-supported accommodation within a low secure setting. Nine patients are accommodated on the ward and four in the Farmhouse which is situated elsewhere within the Bracton Centre grounds.

Heath Clinic was a 13 bed medium secure unit for women with challenging behaviour. Joydens Unit was a13 bed low secure and pre-discharge unit for women in a low secure setting. Joydens had two self-contained first floor flats, each with two bedrooms which provide a semi-independent living pre-discharge facility.

Kelsey was a four bed intensive care area with seclusion facilities. At the time of the inspection the unit it was used by one patient being nursed in long-term segregation. Kelsey was opened in January 2015 and was not staffed independently, but staffed by the ward from which the patient using it originates.

Memorial Hospital had two rehabilitation and recovery wards for men aged 18 to 65 with challenging behaviour, Greenwood and Hazelwood, in a low secure setting. There are 16 beds on each unit.

Both sites provide modern facilities for patients and are accessible by public transport. They each provided opportunities for patients to access local rural and urban facilities.

The Bracton Centre was last inspected in September 2013. Crofton, Joydens and Birchwood were visited as part of that inspection and were found to be meeting all of the essential standards. Greenwood and Hazelwood were last inspected in September 2013 when they were also found to be meeting all of the essential standards.

Mental Health Act monitoring visits were last carried out on Danson in January 2014, Heath in March 2014 and Joydens in June 2014, Hazelwood in March 2014 and Greenwood in March 2015. Provider action statements were issued after each of these visits to address the identified concerns.

Our inspection team

The comprehensive inspection was led by:

Chair: Joe Rafferty, Chief Executive, Mersey Care NHS Trust

Head of Inspection: Pauline Carpenter, Care Quality Commission

Inspection managers: Peter Johnson and Shaun Marten Care Quality Commission

The team that inspected Oxleas NHS Foundation Trust forensic inpatient wards comprised: two CQC inspectors, a CQC Mental Health Act reviewer, an expert by experience (a person with experience of using services), a psychologist, four nurses, a pharmacist and a consultant psychiatrist

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all eight of the wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 41 patients who were using the service
- spoke with one patient who had been discharged from the service
- interviewed the managers or acting managers for each of the wards
- interviewed the service leads for psychology, medicine, occupational therapy and nursing
- spoke with 40 members of staff; including administrators, adult education workers, psychologists, support workers, occupational therapists, therapeutic day workers, support time recovery workers, doctors, nurses and social workers
- interviewed the divisional director with responsibility for these services
- attended and observed four hand-over meetings, a multi-disciplinary patient meeting, two team meetings, two reflective practice sessions and a ward based community meeting
- collected feedback from 29 patients using comment cards
- reviewed 50 care and treatment records of patients
- carried out a check of the medication management on all eight wards and a detailed analysis of fifteen prescription charts
- met with two police officers who worked alongside the service
- received written feedback from a commissioner
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

To understand how people experienced the service, we spoke with 41 patients and looked at 29 comment cards. We also spoke with one person who had been discharged from the service.

Feedback was mostly positive about the care and treatment provided by the service. We received nine comment cards from Greenwood and Hazelwood, eight of which were positive, with one containing mixed comments. Seven of the positive comments related to the way staff treated patients.

We received seven comment cards from Crofton, three were positive, two negative and two contained mixed responses. Three patients commented adversely about

staffing levels or treatment by staff but four patients made positive comments about the way staff treated them. One patient on Joydens left mixed comments about the way staff treated them and one was positive.

There were nine responses from patients on Burgess, two of which were positive about therapy and one was mixed regarding the treatment from staff. Six patients left negative comments, two of which related to the way they were treated by staff, one related to food, the facilities and communication, two suggested the patients did not feel safe on the unit and one was blank. There were no responses from patients on Danson and Birchwood and only one from Heath, which was negative about both staff and the service.

Patients told us staff treated them with kindness, dignity and respect. However, four out of 20 patients told us staff did not always knock their bedroom door before entering. Patients said the wards were clean.

Patients said they felt safe on the wards and knew how to complain if they were unhappy. All except for two patients said they were confident complaints would be dealt with effectively. Very few patients we spoke to said they had had cause to make a complaint. Patients knew how to make a complaint and said they knew about the Patient Advice and Liaison Service (PALS) and how to get support to make a complaint. A few patients had made complaints in the past and there were mixed responses as to the way they felt their complaints had been dealt with.

Most patients said they understood their care and treatment plans, and had been involved in developing them but one patient told two members of the inspection team they were worried about the side effects of their medication and despite asking for a review, they were still receiving it. Six out of seven patients commented that staff were great.

Patients understood their rights and knew how to speak with an advocate if they needed to. They enjoyed the activities and therapy sessions available but some patients felt there should be more activities and 12 patients told us their leave was often cancelled because there were not enough staff on the wards.

Patients used the weekly “community meetings” and some attended ward team meetings and the monthly “User Forum” to provide feedback about the service and to request specific things like changes to the menus.

One patient told us the service was the best one they had used and many other patients were complimentary about the therapy programme, the facilities and the staff.

Patients told us there was always a room they could use to see their visitors.

Staff displayed compliments they had received from patients. One patient had nominated a member of staff for a special recognition award.

Good practice

- Patients had access to a significant amount of meaningful activity. They could take education courses, swim, play hockey and basketball in the full sized gym at the Bracton Centre, be involved in music recording at Greenwood and Hazelwood and take part in inter-ward challenges. Staff linked some challenges to nationally relevant events such as the London Marathon. The service prided itself on the number of patients who entered the Koestler Awards. The Koestler Trust is the UK's best-known prison arts charity. Staff and patients proudly displayed patients’ works of art throughout the Bracton Centre. Police officers and staff supported patients to attend a community judo club and they set up another group at the Bracton Centre. Staff and patients were able to learn judo together. The judo programme was proving successful and the service arranged awards ceremonies to present students with their certificates. At the time of the inspection, an additional judo class for staff was about to begin.
- The service had developed and introduced a “food strategy” in response to growing numbers of patients being at risk of obesity and associated physical health conditions such as diabetes. This was embedded throughout the service.
- The service had developed close links with the local police force’s community safety unit. Two linked

Summary of findings

officers regularly attended the wards and provided support to staff and patients. They were involved in analysing the antecedents to incidents and supporting both staff and patients to consider these. Some patients participated in a restorative justice programme as a result. The substance misuse team supported staff to engage patients in regular drug awareness sessions. The programme was working hard with patients to address education and awareness of legal highs.

- The service had set up social enterprises for patients to earn money for themselves and for the hospital charity. This meant that even patients who did not take part would still benefit from the income generated. Examples included selling sandwiches to staff, selling cakes on a market stall and making then selling picture frames.
- There were real work opportunities available to patients and they could gain work references from external organisations.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that patients are, as far as is reasonably possible, protected from potential ligature risks by considering all ward areas when carrying out ligature risk audits.
- The trust must ensure that staff working in secure services are not left to work alone on a ward.
- The trust must ensure that patients have robust mental capacity assessments to ascertain their capacity to consent to their treatment.
- The trust must ensure that the service complies with the Mental Health Act Code of Practice (2015) guidance on seclusion rooms.

Action the provider SHOULD take to improve

- The trust should ensure that staff record when they offer patients a copy of their care plan
- The trust should ensure that patients are routinely informed of their rights under section 132 of the Mental Health Act, in line with guidance laid out in the Mental Health Act Code of Practice (2015).
- The trust should ensure that patients are given a copy of their section 17 leave forms, in line with guidance laid out in the Mental Health Act Code of Practice (2015).
- The trust should ensure they comply with their own policy on banned and restricted items.
- The trust should ensure that all staff receive regular training and updates on the Mental Health Act Code of Practice (2015).

Care Quality Commission

Oxleas NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Danson Heath Joydens Crofton Birchwood Burgess	Bracton Medium Secure Unit
Greenwood and Hazelwood	Greenwood and Hazelwood

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.

Adherence to the Mental Health Act 1983 (MHA) was generally good across the service. Staff displayed information for patients so they knew how to speak with an independent mental health advocate (IMHA). The service had developed good links with the IMHA team and patients were able to see an advocate when they needed to. MHA paperwork was stored effectively.

However, some patients did not have robust capacity assessments in place to determine if they were able to consent to their treatment. Staff did not routinely record if they provided patients with a copy of their section 17 leave authority form and there were significant lapses of time between patients being informed of their rights under the MHA. The service did not provide MHA training as part of the mandatory training programme. Not all staff had received training in the updated MHA Code of Practice, which came into use in April 2015.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a policy on the Mental Capacity Act 2005 and staff knew how to locate it. Staff were aware of their role to support patients with decision-making. Staff understood the principles of the Mental Capacity Act 2005 and knew who to ask if they needed support for patients. They understood to presume patients had capacity unless evidence suggested otherwise. They knew patients with capacity had a right to make unwise decisions and those who lacked capacity needed to be supported to make a decision.

The multi-disciplinary team were involved in discussions about patient capacity and complex decision-making. It was mostly doctors and social workers who carried out mental capacity assessments. We saw examples of staff supporting patients with decision-making.

Trust data showed that all but one out of 157 staff across the service had completed training on the Mental Capacity Act.

Requires improvement

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

Our findings

Safe and clean environment

- There was a secure entrance to the main hospital building site at the Bracton Centre and to each of Greenwood and Hazelwood wards. Staff facilitated entry to the buildings and to each ward. Access to non-patient areas was by staff operated key only.
- The wards were was visibly clean and well maintained. Corridors were clear and clutter free.
- Annual fire safety risk assessments were carried out. These identified any issues to be actioned and provided dates by which the actions should be completed.
- Patients were responsible for keeping their rooms tidy and domestic staff did the cleaning. The bedrooms we looked at were visibly clean. Patients told us the wards were routinely clean and tidy. Cleaning logs were available for inspection. Domestic staff were a central part of the team and were visible on the wards. The cleaning company undertook regular "deep cleans" of the kitchen areas and these logs were available for inspection. Patient-led assessments of the care environment scores (PLACE) for cleanliness were 98.3% for the Bracton Centre and 99.2% Memorial Hospital in 2015. These scores were higher than the England average of 97.6% and higher than the trust average of 96.1%.
- Staff carried personal alarms. Toilets and bathrooms had red button alarms so patients could summon help in an emergency. Each ward allocated a member of staff per shift to hold responsibility for carrying out environmental and perimeter checks, with the aim of identifying any security or safety risks. These were recorded in a log for all staff to see. Each shift also allocated a dedicated person to respond to alarm calls, on the ward and across the site. This meant it was clear which member of staff would attend emergencies.
- Trust data showed that between April 2015 and March 2016, the service recorded 436 assaults against staff across the service. These included 180 acts of physical / aggression perpetrated from patients toward staff. The highest number, 67, were carried out by patients on Heath. The trust told us the high levels of assaults on Heath related to one patient and they had a strategy in place to deal with this. The trust also told us the rate of assaults on Crofton and Burgess were unusually high in December 2015 and January 2016 as a result of a number of new admissions, the patient mix and a small number of patients using "legal highs". The service had strengthened their work with patients on education of legal highs. They were receiving support from the substance misuse team and the local police liaison workers.
- The trust had a ligature policy and staff adhered to it. Ligature is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. Ligature cutters were available on the wards and staff knew where they were kept. We saw evidence that staff carried out regular ligature risk assessments on all wards except for the Farmhouse (the pre-discharge unit attached to Birchwood). Staff routinely identified areas that needed improvement and a sample of audits over a two year period showed that the estates department or maintenance company carried out improvement work to reduce ligature risks. The service mitigated against the likelihood of patients ligaturing in bathrooms and bedrooms, for example by installing ligature proof door handles and collapsible curtains. However, the trust ligature policy guided staff to only assess ligature risks in areas of the ward where patients may be unobserved. This meant that staff only carried out ligature risk assessments in areas where patients would be unobserved for periods of time, such as bedrooms and bathrooms but not in communal areas of the wards.However, all wards had ligature risks in the communal areas. These included; laundry rooms with exposed cables and pipes; lounge and dining areas with non-collapsible curtain rails, hinged doors, window fasteners, ceiling frets and exposed TV cabling.The light fittings on Heath bedroom corridors could be used for the purpose of ligaturing. Patients could freely access the bedroom corridor; potentially unseen by staff, if they were occupied on other parts of the ward. As part of their therapy, patients could use laundry rooms on the

wards. The trust told us laundry rooms were locked and staff only gave patients individual access following a period of support and assessment. The laundry rooms had plastic sacks lining the bins, exposed electrical cables, metal pipework and plastic pipes, all of which could be used for the purposes of ligaturing.However, at the time of the inspection visit, the door to the laundry room on Heath was unlocked which meant patients could go into the room and potentially be unseen for a period of time. We saw some patients using the laundry. The trust also told us patients could only access the laundry room on Heath following assessment and with supervison. They also said the door to the Heath laundry was locked, but it was in fact open during the inspection visit. Staff consistently told inspectors that they observed patients in communal areas and this, along with individual patient risk assessments, was sufficient to mitigate from the risks of patients ligaturing in these areas.

- Staff also noted there had been no incidents where a patient had ligated in communal areas. Admissions to the service were planned and patients had thorough risk assessments and care plans to address risks. However, the presence of ligature points in communal ward areas and no ligature risk assessment for the Farmhouse meant that the service did not fully protect all patients from avoidable harm. The trust told us they rely upon the individual patient risk assessments to mitigate the risks. However, the Care Quality Commission is of the view that the lack of ligature risk assessments for all ward areas which are accessible to patients, areas constitutes a potential risk to patient safety.
- Patients had a window in their bedroom and could personalise their rooms if they wanted to. Many brought personal items such as pictures and we saw these displayed.
- Patients had a lockable space for their private possessions. Staff were also able to store patients' possessions for safe keeping in dedicated storage areas on the wards.
- Patient food items stored in the independent patient / skills kitchen fridges and freezers were mostly well labelled and in date. However, food items were not always clearly labelled with opened / use by dates on Birchwood.
- The unit displayed hand hygiene signs and sinks were available for patients, visitors and staff to use. We saw staff observing good hand hygiene procedures and they reminded the inspection team to do the same. Staff conducted regular infection prevention and control audits, to ensure people were protected against avoidable risks of infection. Infection prevention and control training formed part of the mandatory training schedule for staff and 93% of them were up-to-date with their training.
- All wards, except for Birchwood, had a clinic room, which was visibly clean and well ordered. In place of a clinic room, Birchwood had suitable alternative arrangements in place for patients and staff. Joydens had received agreement to reconfigure their clinic room to make it more accessible and effective for patients and staff to use because it was cramped, with limited space to move around in. Records showed staff regularly maintained and serviced equipment appropriately. Servicing dates were visible. Emergency equipment and medicines, including defibrillators and oxygen, was in place. Staff checked this regularly to ensure it was fit for purpose and they could use it effectively in an emergency. Staff disposed of sharp objects, such as used needles and syringes, appropriately. The checklist cleaning logs in clinic rooms were up-to-date.
- Staff said the maintenance company carried out repairs in a timely manner. Records confirmed response times were good.
- The unit carried out regular safety tests for electrical items. Testing of items we looked at was up to date.

Safe staffing

- The service did not use a specific acuity tool to determine staffing levels. Acuity is the term used to describe the level of need for care on a ward. The service told us they were considering adopting the Hurst tool but this was dependent upon the outcome of a pilot on other wards. The service told us acuity and staffing was assessed using the clinical judgement of the nurse in charge of the ward, with support from the ward manager or modern matron, which was available to them 24 hours a day. The trust submitted monthly safe staffing figures to NHS England and published them on their website in line with current guidance. These figures show the planned compared to actual staff fill rate for

each ward. Actual fill rates for February 2016 (combining daytime and night time figures) was 106% for nurses and 96% for support workers. For January 2016, the average fill rates were 104% for nurses and 96% for support workers.

- Most staff reported they had enough colleagues on duty to do their job. However, only two staff were allocated to work on Birchwood, one nurse and one support worker. Staff told us the "e-roster" worked out the staffing level for the ward. The trust explained that staffing levels for the wards were agreed in collaboration with the ward team leader, modern matron and head of nursing. Staff told us one member of staff would often work alone on the ward if the other member of staff was facilitating patient leaves. The nurse clinical team lead was sometimes counted in staffing numbers and sometimes not. The therapeutic lead, who was a nurse, was counted in the safe staffing numbers. Managers told us they often had more staff on the ward than their establishment required because staff that were not deemed able to work on the other wards, were sent to work on Birchwood. They said this included staff that had been injured.
- The service implemented the trust lone working policy and staff used this when working alone on the ward. However, sanctioning lone working on a secure inpatient ward meant the service risked the safety of staff and patients, particularly as Birchwood was a forensic medium secure unit and was set apart from other wards on the site.
- In addition to the staffing establishment, the ward manager, modern matron and senior nursing manager were available for support and expertise if required. This support was available 24 hours a day via an on call rota system. These team members were not counted toward ward establishment figures.
- There had been 17 vacancies for nurses across the service but managers had strived to develop an innovative recruitment campaign so, at the time of the inspection, all the vacancies had been filled and many new nurses were in post or about to take up a position.
- The service occasionally used agency staff to work on the wards. They mostly used bank staff and paid their own staff an incentive to work on wards that would otherwise be short of staff (Heath, Burgess and Crofton). This ensured continuity and consistency for patients and staff because it meant they would have familiar staff covering shifts. However, the trust website indicated Heath, Danson and Joydens used both agency and bank staff to cover shifts in December 2015, January 2016 and February 2016.
- Trust data showed that in the twelve months leading up to the inspection, staff turnover across the service was 13.5%. Burgess had the highest turnover rate at 26.9% and Danson had the lowest with 3.6%. Staff sickness rates across the service for the same period averaged 6%. Birchwood had the lowest rate of staff sickness at 2% and Burgess had the highest rate at 9%.
- Ward staff and other members of the multidisciplinary team supported patients to attend therapeutic activity and rehabilitation programmes during the working day. There were assistant psychologists, therapeutic working day workers, occupational therapists, psychologists and education staff who all provided support to patients.
- Staff had undertaken training relevant to their role. Across the service, 94% of staff were up to date with their mandatory training. This included: conflict resolution 100%; prevention and management of violence and aggression 85%; basic life support 95%; three levels of safeguarding children training with a combined average of 92%; safeguarding adults 98%; fire safety 96%; health and safety 97%; food safety 82%; and infection control 93%.
- All new staff received an induction to the unit. The induction process covered environmental and patient risk issues.
- Twelve patients told us their escorted leave was sometimes cancelled because of staff shortages. Patients said they found this annoying. Trust data showed that for the 122 patients in the service during March 2016, 22 leaves were cancelled but staff facilitated 1784.During April 2016, the same number of patients took 1718 leaves and only eight were cancelled.
- The service had safeguarding policies and procedures. All staff we spoke to demonstrated a good understanding of how to identify and deal with potential safeguarding concerns. They also knew where to get help and advice if they needed it.

Are services safe?

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

- Staff told us there was adequate medical cover day and night. A local GP service provided out of hours physical healthcare cover. There was also a senior nurse on-call rota.

Assessing and managing risk to patients and staff

- Almost all patients and staff told us they felt safe on the wards.
- Staff carried out individual risk assessments for all patients. Risk assessments were clear and staff linked them to individual care plans. Staff regularly updated them and routinely assessed patients before they took leave and when they returned to the unit. All patients had an up-to-date Historical Clinical Risk Management assessment tool (HCR20). The HCR20 is a comprehensive set of professional guidelines for the assessment and management of violence risk. Staff developed crisis and contingency plans with patients.
- The service had appropriate policies to manage risks, such as a list of items that were not allowed on the unit and a search policy. We noted that plastic bags were on the banned items list but most wards had an array of plastic bags and plastic sacks, often used to line bins and sometimes in areas where patients spent unsupervised time, such as bathrooms and laundry rooms.
- Staff used shift handover meetings to discuss individual patient risk, incidents, therapy plans and leave arrangements. The meetings were effective which meant staff shared important information well. Security arrangements were not included in the main shift handover but were discussed between the outgoing and incoming security lead for each shift. If necessary, the security leads shared information with staff in the ward handover meeting.
- The service had seclusion rooms on Heath, Burgess, Hazelwood and the new ancillary unit called Kelsey, which was aligned to Crofton. Seclusion is the term used for the supervised confinement of a patient in a room, which may be locked. The sole aim of seclusion is to contain severely disturbed behaviour, which is likely to cause harm. The Mental Health Act Code of Practice provides guidance for the use of seclusion. There were 37 incidents of seclusion recorded across the service between February and April 2016 of which 19 took place on Heath, 12 on Burgess, five on Kelsey and one on Hazelwood. We looked in depth at the seclusion records for three patients on Heath. We found the seclusion record sheets were not individualised for each patient and hourly reviews and outcomes were not completed in all cases. Several reviews were not dated and records did not indicate if staff offered patients support after their seclusion had ended. We looked at the patients' care plans and did not see a strategy to cover the potential use of seclusion. Care plans did not record what interventions would be implemented in the event that the patient's challenging behaviour escalated.
- We looked at the seclusion facilities across the service. The seclusion suite on Kelsey was relatively new. The facilities were light, spacious and included CCTV, toilet and washing facilities, a mattress, externally controlled lighting, and a visible clock. There was no formal two-way communication mechanism but communication between staff and anyone using the facility was not compromised. There was no screen for the toilet area, which potentially compromised patients' privacy and dignity. There was also no closable viewing panel that might afford some privacy for a patient using the toilet. However, the toilet was partially recessed into the wall which did provide a degree of privacy. A Care Quality Commission (CQC) Mental Health Act monitoring visit took place shortly after the inspection on 4 May 2016. CQC asked the trust to provide an action statement detailing how they would adhere to the principle of dignity and respect by modifying the seclusion facility to afford some privacy to a patient using the toilet. The trust explained they had carefully balanced safety and dignity when designing the seclusion facility on Kelsey. They noted only the member of staff carrying observations would be present when a patient used the toilet and staff were aware that they should not observe the patient directly when they were using the toilet, unless the risk assessment indicated otherwise.
- The seclusion facility at Hazelwood was primarily used for patients on Hazelwood but patients on Greenwood also used it when necessary. It had not been used by Greenwood patients between February and April 2016. As the wards were not linked, it could only be accessed by exiting the security of the ward environment and travelling approximately 75 yards using the pavement of a private road used by cars on the hospital site. Therefore, the seclusion facility on Hazelwood was not easy for Greenwood staff and patients to access.

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However, the trust had plans to carry out substantial building works to link the two wards by 2018. These plans included upgrading the seclusion facility so it was modern and easily accessible to both wards. The de-escalation and seclusion room were sited together, off the main ward area and accessed from both Hazelwood reception and the ward. The seclusion room was accessed from the de-escalation area. Views into the seclusion area were limited when the door to the de-escalation room was closed but there were viewing panels for staff to see inside. Natural daylight and ventilation was provided by an externally controlled ceiling mounted skylight at high level. There was an en-suite facility and externally controlled under floor heating. There was no view of outside space.

- The seclusion and de-escalation facility on Heath had a number of issues, which included limited viewing areas so staff could not freely observe the patient. To allow staff better views inside the seclusion area, a plastic tube of roughly 35cm diameter and 50cm in length had been fixed through the wall from the de-escalation room corridor area into the seclusion room. The pipe had a plastic cap, which attached from the corridor and allowed some limited sight into the facility. The de-escalation and seclusion suite was a combined unit, located off the communal patient area, between the staff office and patient kitchen. This afforded limited privacy for patients using the de-escalation room because patients could look through the viewing panel in the door. Noise could travel from the ward area into the de-escalation suite and from the suite into communal patient areas. The trust later told us patients on Heath could use the “Snoezelam” room for de-escalation purposes if they wanted to. Temperature of the seclusion room could be controlled from the staff office. There was no two-way communication; staff had to talk through the door to communicate with a patient using the seclusion facility. The door was split above the viewing panel and the trust later told us this had been reported to the maintenance team. There was a reinforced frosted window allowing natural light into the area while maintaining the privacy of a patient using the facility. Patients could climb to the heating vent. There was a clock for patients to see but there was no date on it. This seclusion facility did not meet with the guidelines set out in the Mental Health Act Code of Practice (2015).
- We asked the trust what plans were in place to modify the seclusion facilities within the service. They told us the estimated completion date for works to Heath seclusion area was March 2017. They told us there were two seclusion rooms on Burgess, one of which was decommissioned and last used in December 2015, the other of which was still in use and last used in April 2016. We were not able to see that room on Burgess because it was in use at the time of the inspection. The trust told us they planned to decommission the intensive care area on Burgess in May 2017, once works had been completed to merge Danson and Kelsey and make it a male acute ward with an integral intensive care area.
- Between April 2015 and March 2016, the service nursed two patients in long-term segregation. We found that documentation was effective and patients nursed in long-term segregation had exit and reintegration plans in place.
- Rapid tranquilisation was used 30 times between December 2015 and February 2016. Heath had the highest use of rapid tranquilisation with 22 incidences followed by Burgess with four.
- Training on conflict resolution and the prevention and management of violence and aggression was mandatory for all nurses and support workers on the wards.
- Staff and patients told us that staff only used restraint as a last resort and they minimised the use of face down, prone restraint. Restraint is any direct physical contact where the intervener’s intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person. Prone restraint describes a type of restraint which is holding a patient chest down, whether the patient placed themselves in this position or not, resistive or not and whether face down or to the side. It includes being placed on a mattress face down whilst in holds; administration of depot medication whilst in holds prone, and being placed prone onto any surface.
- Between February and March 2016, there were 54 incidents of restraint across the service. The highest number of restraints took place on Heath, the female challenging behaviour and medium secure ward. There were 38 incidents of restraint on Heath, 10 of which were in the prone position. Of the incidents on Heath, 19

related to one patient who was waiting to be assessed for a move to high secure care. During the same period, there were seven incidents of restraint used on Burgess, three of which were in the prone position and four incidents on Crofton, one of which was in the prone position. The Department of Health's 2014 guidance Positive and Proactive Care states that providers should work to reduce the use of all restrictive interventions and focus on the use of preventative approaches and de-escalation. The guidance also states that "there must be no planned or intentional restraint in the prone position". A more recent update from the DH has clarified that "it is accepted that there may be exceptional circumstances where the use of prone restraint will happen".

- We reviewed the medicine administration records of all patients in the service. Staff had a good knowledge around error reporting for medication and identified when errors in medication administration or prescribing had occurred. Managers compiled reports and staff discussed them in staff meetings so they could learn from them. Self-medication plans were appropriately managed. We looked in depth at fifteen prescription charts across Joydens, Heath and Danson. All five charts on Danson showed missed doses with no reason recorded and some of the omitted medicines on the charts should not be stopped abruptly. Three of the five charts on Joydens showed missed doses with no reason recorded and one showed a prescription which was not signed by a doctor. Ten out of the fifteen prescription charts on these three wards did not record patients' allergies on their electronic records but all except one documented allergies on the paper prescription charts.
- The service had access to a pharmacy department, based at the Bracton Centre. They provided oversight of ward systems and managed the prescription service. A pharmacist or technician visited the wards every week. Records showed staff stored and disposed of medication effectively. When medication errors occurred, these were detected, recorded and investigated. We saw that patients were informed when this happened and staff were able to look for lessons to be learned from such incidents. Staff said they received a good response from the pharmacy team when they needed them.
- The service held regular meetings to consider risk. Meetings included the good practice meeting, the red flag meeting and the security meeting. The trust had a "risk register" where they recorded risk and the service could feed items into this register so senior managers were kept informed.

Track record on safety

- In the 12 months leading up to the inspection, there were no serious incidents requiring investigation.

Duty of Candour

- The duty of candour requires providers to be open and transparent with patients when something has gone wrong. The trust had a duty of candour policy. Staff understood the principles and knew where to find the policy. The trust provided staff with a "pocket guide" to services and support, the duty of candour was detailed in this handy guide for staff to reference. Wards also referenced the duty of candour in their team vision statement. If they made mistakes, staff understood the importance of being open and transparent with patients. We saw good examples of staff adhering to the trust's duty of candour policy.

Reporting incidents and learning from when things go wrong

- Staff we spoke to knew how to recognise and report incidents of harm or risk of harm. They were confident they could report incidents without fear of recrimination. The service had a clear incident reporting policy and staff were aware of how to access it.
- Staff used an electronic system to record incidents. This information was sent to managers and senior managers for their action and attention. Staff used handovers and team meetings to share information about risks and incidents. They kept minutes of these discussions for other staff to read. Managers offered staff and patients de-brief meetings following incidents.

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.

Our findings

Assessment of needs and planning of care

- We looked at 50 patient care and treatment records. Staff carried out thorough patient assessments. Care plans addressed individual patient needs. They were holistic, covering all aspects of patient need. Staff reviewed and updated care plans regularly.
- Occupational therapy, medical, nursing and therapy staff worked together to plan and deliver patient care. The team maintained contact with the patients' home teams and families.
- Staff routinely held Care Programme Approach (CPA) reviews to collect and monitor patient outcomes. Patients, their families and relevant professionals were involved in these reviews.

Best practice in treatment and care

- The service provided patients with ease of access to a range of psychological therapies. Therapies included psychotherapy, cognitive behavioural therapy and family therapy work. The service also provided a wide range of group therapies for patients including; anger management, know your own risk, headspace, and problem solving and life management skills. They also offered a sex offenders treatment programme and a drug awareness programme.
- The service had an identified physical healthcare lead, a general nurse, as well as mental health nurses. Staff were able to carry out screen assessments for learning disabilities and autistic spectrum disorders. Records showed staff effectively identified and managed patients' physical healthcare needs. Patients told us staff supported them well with their physical healthcare needs.
- The service used a visiting optometrist and a mobile dentist to support patients with their optical and dental care needs. The service could access the support of a dietician for specific patient needs but also for general advice and support with the food strategy and healthy eating.
- Staff supported patients who wanted to stop smoking and could provide smoking cessation products. Prescribing followed National Institute for Care Excellence (NICE) guidelines for Stop smoking services (2013).The service was a smoke free area and staff had researched the area and put plans in place to support patients. They had decided to revisit the support available to patients because there were a number of new of patients who were new to living in a smoke free zone.
- Ward staff met at each shift change to handover information. We saw these meetings were effective in handing over important patient and service information from one shift of staff to another.
- The service used the Royal College of Psychiatrists' Health of the Nation Outcome Scales (HoNOS). This was the most widely used routine clinical outcome measure used by English mental health services.
- Prescribing followed National Institute for Care Excellence (NICE) guidelines such as Psychosis and schizophrenia in adults: prevention and management (2014).
- The service used an electronic patient record database. Staff recorded assessments and daily updates in this system. Certain records, such as seclusion records, were completed using paper notes and were later uploaded electronically by administrative staff. We found there had been some delays in this uploading of information because here had been vacancies within this team. This meant that not all records were easily available to staff in a timely manner. Delays in accessing records could lead to a risk for patient care.

Skilled staff to deliver care

- The service had identified staff to lead in specialist areas and some healthcare support workers were trained in phlebotomy.
- Staff received appropriate training, supervision and professional development. Some staff told us they had been given a lot of support to learn new skills or update their skills. Most had been given development opportunities such as time off for study leave, time off for research and financial support to undertake higher education programmes including diplomas and master's degrees.

Multi-disciplinary and inter-agency team work

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- Staff working across the service came from a range of professional backgrounds including nursing, medicine, occupational therapy, dietetics, hospitality, psychology, family therapy, social work, sports therapy and management. The service worked with local universities to provide student work placements.
- Staff carried out multidisciplinary assessments and the different professions worked well together.
- Multidisciplinary team meetings (MDTs) and Care Programme Approach meetings (CPAs) took place regularly and patients routinely attended. Staff typed MDT and CPA notes into RIO during the meeting so they were open and transparent to the patient. Patients were included as full partners in their meetings and staff sensitively managed patients' comments and views. Carers, family members and community team staff attended the meetings when they could.
- The service maintained contact with their commissioners and with patients in other services who were planning to be admitted to the Bracton Centre as part of their proactive discharge planning system.
- Staff kept in touch with patient's community teams and kept them informed of progress if they were unable to attend patient meetings.
- Patient care and treatment records showed there was effective multidisciplinary team (MDT) working taking place.

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

- Adults who are in hospital can only be detained against their will if they are sectioned under the MHA or if they have been deprived of their liberty under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS). If patients are not subject to the MHA or the MCA DoLS, they can leave the unit, so need to know their rights. Patients we spoke to knew their rights. They knew they were detained under the MHA. There were no patients subject to a DoLS.
- When we carried out this inspection, all patients within the service were formally detained under the Mental Health Act 1983. The use of the Mental Health Act (MHA) was mostly good across the service and MHA paperwork was correctly stored. Records clearly showed communication between the wards and the Ministry of Justice when this was relevant. Patient records contained admission and MHA section paperwork.
- Completed consent to treatment forms were routinely available to inspect. Staff administered medication covered by T2 or T3 paperwork, which meant the medication patients received was authorised by an approved doctor. Form T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate issued by a second opinion appointed doctor and is a form completed to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can therefore, be provided without the patient's consent. One patient on Heath was prescribed medication not covered by their T2 form. Medication for all other patient records we looked at was covered by the appropriate T2 and T3 documents.
- We looked at five care records on Hazelwood and found staff had completed and recorded thorough capacity assessments for each of the patients. Staff recorded discussions with patients about their medication, which the patients had then signed.
- We looked in depth at the records of six patients on Heath and carried out interviews with five of them to better determine their understanding of their treatment plans. We found a higher proportion of patients covered by a T2 than we might expect in a similar service and a lower proportion than we might expect of patients covered by a T3. The trust told us this was because patients on this ward. Some patient files on Heath ward contained no information in the section for patient views on medication and treatment. Three out of six patient records contained the statement "covered by T2" in the section which should have recorded the patient views. When we spoke to them, we found all of the five patients lacked information about the side effects of their medication. Three out of the six records did not include patient views in the assessment. Three out of the six records showed medication had been discussed in multidisciplinary management. One patient told us they did not fully understand their medication but had been given a leaflet about it.

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However, they told us they could not read and staff had been too busy to read the leaflet to them. We would have expected to see robust capacity assessments for patients with highly complex, challenging and mixed mental health needs, but these robust assessments were not evidenced in all the files we examined on Heath ward.

- The responsible clinician completed the granting of section 17 leave forms. Staff risk assessed patients before section 17 leave took place. Parameters and conditions of leave were evident in patient records. Sections 27.22 of the MHA Code of Practice (2015) states that patients should be given a copy of their section 17 leave authorisation. Staff said they routinely gave patients a copy of their leave forms. However, we could not evidence this, so we looked in depth at six patient files on Heath and in all six cases there was no record that staff had given patients a copy of their leave authorisation. We looked at a further 16 patient files on Crofton, Birchwood, Burgess and Hazelwood and found only three patients were recorded as having been given a copy of their section 17 leave form. This meant that out of the 22 records we looked at, 86% had no recording to evidence that staff gave patients a copy of their leave form. Staff on Hazelwood told us they did record when they offered the patient a copy of their leave form but unfortunately they were not able to find any evidence to support this, despite looking for it. Even though we could not evidence that patients were routinely given a copy of their section 17 leave form, we saw that staff were facilitating large numbers of regular patient leave.
- Section 17 leave forms were crossed through when they were no longer in date but staff did not remove them to archive. Consequently, there were a large number of leave forms in the files we examined.
- The wards displayed information on the rights of detained patients and details of the independent mental health advocacy (IMHA) service. Staff and patients knew how to ask for an advocate.
- Patients were able to access Mental Health Act Tribunals and managers' hearings when they needed them and these took place on site at either Memorial Hospital or the Bracton Centre. Patients were supported by IMHAs if they needed them.
- Sections 4.28-4.29 of the MHA Code of Practice (2015) states that patients should be reminded of their rights from time to time and a fresh explanation of their rights should be considered when for example there is to be a care programme approach review; the renewal of their detention is being considered; the patient is considering applying to the Tribunal; or when the patient becomes eligible to apply to the Tribunal. Staff were aware of the need to explain patients' rights to them and patients told us they understood why they were detained in hospital.
- We asked a doctor if patients were routinely informed of their rights and we were told a recent audit had shown 100% of patients were informed of their rights when they were admitted to the service. The doctor also told us patients were routinely reminded of their rights in line with the Mental Health Act Code of Practice (2015). We checked 19 records across the service and found that six (32%) did not contain evidence that staff had informed patients of their rights when they were admitted. Some staff, including a Mental Health Act administrator, told us there was a specific place in the patient record database where staff should record when they advised each patient of their rights. When we looked in this specific part of the patient record data base and found the information missing, we also looked for it in other parts of the database where it could have been recorded such as the daily record,. Overall, we found that of the 38 records we looked at, only 66% (25 records) showed evidence that staff had recorded when they advised patients of their rights in the months leading up to the inspection. One patient on Heath had not been advised of their rights since June 2015 even though they had had their section renewed. Another was advised of their rights in November 2014 and again in March 2015 but not since. One patient record showed the patient who had not been advised of their rights since August 2014.
- Staff did not undertake training on the MHA as part of their mandatory training. E-learning modules were available and staff said they could request training from peers and others within the service if they felt they needed it. Managers said they might suggest staff undertake some training if they felt it was needed. Staff said they had not received any training on the revised MHA Code of Practice, which came into operation in April 2015. The trust told us qualified staff undertook

training on the MHA as part of their initial training and that preceptor training was given to newly qualified staff. They said specific training had been delivered to staff regarding the parts of the revised Code of Practice which were relevant to the service. Nonetheless, staff told inspectors they had not had any training or updates on the revised MHA Code of Practice. We would expect all staff working in specialist mental health services to undertake regular training and updates on the Mental Health Act Code of Practice 2015.

- The service had recently introduced changes to the function and purpose of some wards. The change had been driven by the commissioners of the service, and not by the trust. Joydens had changed from medium secure to low secure. However, not all patients had moved in line with the new functions of the wards. One patient we spoke with was confused about the change and not sure what it meant for them. Staff told us not all patients on Heath had been assessed for the potential for them to move to Joydens. This meant some patients could be receiving care and treatment that was disproportionate for their needs and may not be the least restrictive option in line with the Mental Health Act 1983.
- Staff said they knew how to contact their Mental Health Act administrator for advice when needed.

Good practice in applying the Mental Capacity Act

- The trust had a policy on the Mental Capacity Act 2005 and staff knew how to locate it.
- Staff were aware of their role to support patients with decision-making. Staff understood the principles of the Mental Capacity Act 2005 and knew who to ask if they needed support for patients. They understood to presume patients had capacity unless evidence suggested otherwise. They knew patients with capacity had a right to make unwise decisions and those who lacked capacity needed support to make a decision.
- Staff demonstrated a good understanding of supporting patients to make decisions and could give examples of decision specific assessments.
- Doctors completed mental capacity assessments with patients on a regular basis for the purposes of consent to treatment. However, these were not always detailed.
- Most capacity assessments we saw related to consent to treatment rather than broader decisions and were not detailed, which meant we could not see how the doctors had reached their decision about patients' capacity. The culture of the wards meant it was mostly doctors and social workers who carried out mental capacity assessments, the nursing staff did not routinely complete fully capacity assessments.
- The multi-disciplinary team were involved in discussions about patient capacity and complex decision-making.
- We saw examples of staff supporting patients with decision-making.
- Staff said they would speak with colleagues or a doctor if they needed support with aspects of the MCA.
- A social worker had recently provided some training on the MCA to staff at Greenwood and Hazelwood. Staff told us the trust had recently tried to increase staff awareness of the MCA and trust data showed that all but one out of 157 staff across the service had completed training on the Mental Capacity Act.

Are services caring?

Good

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

Our findings

Kindness, dignity, respect and support

- Patients told us staff treated them with kindness and respect.
- We talked to staff about patients and they discussed them in a respectful manner and showed a good understanding of their individual needs.
- We saw patients were able to approach staff freely when they wanted help and support or if they were upset. Staff were able to identify when patients needed emotional support and we saw them offering this in an individualised way.
- We observed staff interacting with patients in a caring and compassionate way, showing appropriate levels of humour. Staff responded to patients in a calm and respectful way. Their interactions were natural and open. We saw staff listening well and having productive discussions with patients.
- Patient-led assessments of the care environment scores (PLACE) for privacy, dignity and wellbeing were 94.7% for Memorial Hospital and 93.2% for the Bracton Centre. These scores were higher than the trust average of 91.6% and higher than the England average of 86%.
- Patients told us they believed staff were genuinely interested in their care and wellbeing.
- Staff appeared passionate and genuinely interested in providing good quality care to their patients. They were very proud of the therapies and activities they could provide for patients.
- Staff supported patients to keep up their own support networks such as with their families, friends and communities. Patients told us staff enabled to do quality activities with their children when they came to visit. One example given was cooking with their children. The visiting suite was situated in a house with a garden on the site; it was homely and had kitchen facilities and toys for children.
- Staff supported most patients to meet their religious, spiritual and cultural needs. Some patients were supported to meet their spiritual needs in the community with family and friends; others used the facilities on site at the Bracton Centre.
- Sixteen out of twenty patients we asked said staff always knocked their bedroom door before entering.
- Staff described the importance of carrying out personal searches of patients in a way, which balanced safety and security with dignity and privacy.
- Staff supported patients to deal with all aspects of their care and treatment needs including their emotional and physical health needs. The service provided therapies which included the patients' families.

The involvement of people in the care they receive

- Patients could visit the unit before admission. The service had developed a patient information booklet. Most patients remembered receiving this. There was information on the trust website, which gave limited information about the service, but the patent information booklet gave patients a lot of useful information about what to expect from the service.
- Patients were involved in giving tours of the wards and explaining what was available within the service. There were also ward roles and tasks they could volunteer for.
- Staff encouraged patients to be actively engaged in their activity programmes, in therapy and in developing their care plans. Many patients remembered being given a copy of their care plan but staff did not routinely record when they had done this.
- Patients were encouraged to attend the “user forum” and carers to attend the “carers forum”.
- We saw patients were able to express their views, which staff reflected in the key documents they prepared. Care plans were written in a person centred way and were holistic, which meant they covered all aspects of the patients' care and support needs
- Staff encouraged patients to attend their multidisciplinary (MDT) meetings.
- Patients, their families and their community team attended regular Care Programme Approach (CPA) meetings.
- The wards held weekly community meetings where patients could have a say in the running of the ward.

Are services caring?

Good

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They could give suggestions and make requests for changes to things like menu plans or activities. Patients took responsibility for chairing the meetings. Staff circulated the minutes for future reference.

- The service ensured that patients knew how to contact an independent advocate. They displayed posters and leaflets for the local advocacy service in communal areas of the wards and in the reception areas. All the patients we spoke to knew how to get an advocate. The advocate came to see them regularly and supported them in CPAs and MDTs.
- The unit staff also ensured patients could use an independent mental health advocacy (IMHA) service if they needed to. The unit displayed signs for the IMHA service in patient areas and in the reception. Patients could use the ward phone to make free calls to the IMHA or to their solicitor if they needed to.
- The service had a policy on the use of mobile phones, cameras and internet access. The restrictions were reasonable for a forensic environment.
- There were comment boxes in the reception area for patients, family, visitors or staff to post comments.
- Some wards displayed “You said, we did” posters. This showed patients what the service had done to respond to their feedback. Birchwood patients had asked for full-length mirrors to be installed on the ward and staff had arranged for this to be done. The “You said, we did” poster highlighted showed this as one example.
- Patients and family were routinely encouraged to provide feedback about the service. We saw the service listened to feedback and changed the way they did things as a result, an example was the way they introduced the smoke free policy. They listened to the concerns and ideas put forward by patients and staff.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Staff carried out pre-admission assessments quickly depending upon vacancies. Patients were admitted from the local geographic area but may be admitted from a service further afield as part of their discharge plan. A psychiatrist and a nurse carried out pre-admission assessments. The service did not take emergency or unplanned admissions.
- Bed occupancy averaged 98% between 1 April 2015 and 31 March 2016. Heath and Joydens had the lowest occupancy rates at 95%. Burgess, Danson and Hazelwood had 100% bed occupancy. The service kept an empty bed on Danson should a patient be recalled by the Ministry of Justice or need to be transferred from another ward.
- Average length of stay in the service was 756 days. Danson had the highest length average of stay at 1443 days. Burgess had the lowest length of average stay at 219 days.
- In the 12 months leading up to the inspection, 24 patients were placed in commissioned beds which were out of area.
- Staff considered discharge planning as part of patients' admission and planned discharge arrangements in conjunction with patients and their families as well as with their NHS commissioners and community teams. Some patients experienced a delay in their discharge but this was normally due to circumstances beyond the control of the service, such as delays in finding a suitable placement to move on to or delays in finding suitable housing. Between October 2015 and March 2016, nine patients experienced delays in their discharge. The highest number of delays were on Birchwood, the pre-discharge ward, where five patients were delayed. However, the service was not responsible for these delays because patients were waiting for suitable accommodation to move on to.
- Staff liaised with local teams to address delays in discharge, even though they had no control over the availability of other resources. The service was involved with community partners to develop accommodation for patients to move onto with the aim of supporting patients to achieve a timely discharge.
- We saw no evidence of patients having to move between wards because of non-clinical reasons.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had a full range of rooms and equipment for staff and patients to use as part of the treatment and therapy programme. This included space for therapeutic activities, relaxation and treatment. The buildings were modern and rooms were light and airy. Furniture was comfortable and modern.
- Some wards provided patients with en suite facilities and others had shared toilet, bath and shower facilities. There were enough bathrooms and toilets so patients did not have to wait long to use them.
- All patients had their own rooms, which they could personalise if they wanted to. All wards were single sex so patients did not have to share facilities with member of the opposite sex. There were specific rooms where patients could meet their friends and families for visits and there were rooms where they could meet staff for privately discussions.
- Four patients on Birchwood were on self-medication programmes to support their independence skills and discharge planning.
- All wards had communal areas where patients could meet with each other, sit and watch TV, read or play games. There was a selection of activities, such as games and table tennis, for patients to use on the wards.
- Patients could take part in education and skills training. They could learn new skills such as car mechanics and bricklaying or they could study for courses that would lead into further education, such as computing, English and maths.
- The service had a patient experience group, a user forum and a carers forum as a way of engaging patients and their families.
- There were therapy kitchens and snack stations on all the wards so patients could make their own meals and

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snacks. Patients had a kitchen skills and a risk assessment to see what kind of support they needed form staff. Depending upon risk assessments and individual treatment plans, patients could use the kitchens to make their meals, drinks and snacks.

- Therapy staff developed individual support plans for all patients. Activities were available in the evenings and weekends on most wards. The trust had introduced evening and weekend activities in response to feedback from patients and staff. Patients had access to a significant amount of meaningful activity. Activities were led by the therapeutic working day and occupational therapy staff with support from ward staff. One patient told us they really respected their psychiatrist because they were willing to join in with patient activities such as gardening.
- Patients could take education courses, swim, play hockey and basketball in the full sized gym at the Bracton Centre, be involved in music recording at Greenwood and Hazelwood and take part in inter-ward challenges. Staff linked some challenges to nationally relevant events such as the London Marathon. The service prided itself on the number of patients who entered the Koestler Awards. The Koestler Trust is the UK's best-known prison arts charity. Staff and patients proudly displayed patients' works of art throughout the Bracton Centre.
- Relaxation and judo classes were offered. The judo programme was run in conjunction with the local Dartford Police Community Safety Unit. Police officers and staff supported patients to attend a community judo club and they set up another group at the Bracton Centre. Staff and patients were able to learn judo together. The judo programme was proving successful and the service arranged awards ceremonies to present students with their certificates. At the time of the inspection, an additional judo class for staff was about to begin.
- The service had developed close links with the local police force's community safety unit. Two linked officers regularly attended the wards and provided support to staff and patients. They were involved in analysing the background or antecedents to incidents and supporting both staff and patients to consider them. Some patients participated in a restorative justice programme as a result. The presence of the officers also encouraged patients to see the Police as a means of support they could draw upon after they were discharged.
- Patients could manage their own laundry if they were assessed as able to. There were laundry rooms for them to use and the service provided free laundry products.
- Some patients had their own mobile phones but for security reasons these were not freely available. Patients could keep in touch with their family and friends by using pay phones, which were situated on each ward.
- Some patients complained the phones were not very private and a number of patients said the phones kept breaking down, which frustrated them. We saw staff being supportive of patients and allowing them to use the ward phone if they wanted to make a call. Patients were allowed to make free calls from the ward if they wanted to speak to a solicitor or an advocate.
- The service had developed and introduced a "food strategy" in response to growing numbers of patients being at risk of obesity and associated physical health conditions such as diabetes. This meant there was an emphasis on healthy eating and activity. Staff combined this with the "wellbeing Wednesday" groups. A small number of patients complained the portions were too small but most patients we spoke with were satisfied with the way the food strategy had been implemented.
- We saw patients discussing menus in a community meeting which the patient representative then fed back to the team meeting. Arrangements were in place for patients with special dietary requirements and for patients with specific cultural and religious requirements. Staff ordered dry goods, chicken and salmon then patients shopped for fresh ingredients. Staff supported patients who needed help to shop and cook. Patients on the pre-discharge wards were given a cash allowance with which to buy their food. Patients told us they liked this freedom. They were able to bulk purchase items and store them in their allocated kitchen cupboards or in a jointly shared freezer. Patients and staff had training in basic food hygiene. We saw good food hygiene procedures but not all patients correctly labelled their food in the fridge, so it was not

Are services responsive to people's needs?

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always possible to see labels showing the date an item had been opened and the date by which it should be consumed. Each ward had a dining room where patients could eat their meals.

- The service had set up social enterprises for patients to earn money for themselves and for the hospital charity. This meant that even patients who did not take part would still benefit from the income generated. Examples included selling sandwiches to staff, selling cakes on a market stall and making then selling picture frames. Patients were very positive about their involvement in these enterprises. They were able to gain new skills and build their confidence.
- There were real work opportunities available to patients and they could gain work references from external organisations, thereby improving the likelihood they could secure meaningful employment following their discharge. Work and voluntary work opportunities included picture framing, car washing, bricklaying, catering, retail customer services and motor mechanics. Patients could study for qualifications to support these work opportunities.

Meeting the needs of all people who use the service

- Staff respected patients' diversity and human rights. They received training in equality and diversity (E&D) as part of their mandatory training programme and 96% of staff across the service were up to date with this. Staff made meaningful attempts to meet patients' individual needs including cultural, language and religious needs.
- There was a multi-faith room at the Bracton Centre. A number of patients said they used it but not all patients were aware of it. The service had a linked spiritual advisor and most patients knew of them and said they could get spiritual guidance if they wanted it. Several patients at Greenwood and Hazelwood were supported by their families and staff to attend a place of worship in the community. Only one patient, on Heath, told us they were unaware there was support available to meet their spiritual needs and they had not been able to practice their religion.
- Patients told us leaflets were available in other languages and in easy read formats. However, one patient told us their doctor had given them a leaflet about their medication but they could not read and staff had been too busy to read it to them.
- The service was accessible for people who used wheelchairs including some bathrooms.
- The service was responsive to the way it supported individual patients. One patient told us they liked to rise early in the morning and use the gym before anyone else was up. They were happy that staff were willing to facilitate this for them.

Listening to and learning from concerns and complaints

- The service displayed information about how to make a complaint in reception areas and in communal patient spaces. They also displayed information about the independent mental health advocacy service and CQC. Patients told us they knew how to make a complaint and were confident they could do so. The advocate and the Patient Advice and Liaison service (PALS) supported patients to make a complaint if they needed help. Patients told us they had a mixed experience of responses when they had made complaints. However, almost all patients felt they would be taken seriously if they did make a complaint. They could raise concerns and complaints in the community meetings, directly to staff or by submitting a formal complaint. They could submit complaints anonymously if they wanted to.
- Staff told us they had an open culture for complaints and encouraged patients to make their views known. The service had co-produced a video with patients about complaints, which encouraged them to do so, as a way of empowering patients and providing a learning opportunity for staff. The service investigated complaints and provided feedback to patients. Between May 2015 and March 2016, there were nine recorded complaints made by seven patients, covering 31 subject areas. The most common complaint subject was attitude and behaviour, with 11 followed by communication with five. Of the nine complaints, out of the 31 subject areas one was upheld, two were partly upheld, 26 not upheld and two were indeterminate. When staff made a mistake, we saw that they were open and transparent with patients and provided an apology.
- Staff and managers told us they were open to receiving both positive and negative feedback and considered all feedback as a learning opportunity.

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.

Our findings

Vision and values

- Staff were aware of the trust's vision and values: user focus, excellence, learning, responsive, partnership and safety. Some were eager to demonstrate these and all staff we spoke to appeared to be genuinely interested in doing the best they could to help their patients move forward. The trust provided staff with a "pocket guide", which detailed their values and priorities, showed the senior management and board members, explained the Duty of Candour and detailed how staff could provide feedback or get support if they needed it.
- Staff told us they felt valued by their managers and by the service. They believed they could express their views and were encouraged to give feedback.
- Patients and staff knew senior managers by name and were used to seeing them on the wards. They were aware of the trust board members and said some had visited the service.

Good governance

- The trust told us they relied upon individual patient risk assessments to mitigate against the risk of potential ligatures in communal patient areas of the wards.
- We found it was difficult for staff to evidence a timeline between when they carried out the ward based ligature audits and when the work to remove or modify risks had taken place. However, the Trust was able to evidence how actions arising from ligature audits were logged, managed and actioned.
- The trust and the service had developed an internal governance structure to support patients and staff.
- There were processes in place to report then investigate incidents and complaints. They had polices to protect patients and staff from avoidable harm. Staff knew the policies and knew where to find them.
- Managers gathered performance data and used it to address quality and staff performance issues. At the time of the inspection, there were no staff grievance procedures and there were three disciplinary procedures on going. Clinical team leaders said they had enough time and autonomy to manage their wards effectively. They said they were able to get support from the senior nursing team and from each other when they needed it. The service held a regular senior nurse meeting, which records showed were well attended and documented. This gave local managers the opportunity to learn and share information while providing consistency in approach across the different wards.
- Managers made sure that staff had regular supervision and appraisals. These were documented and recorded. An average of 90% of ward staff and 74% of medical staff had received an appraisal within the last year. The highest rate of appraisals completed for ward and medical staff was on Heath with 96% and 100% respectfully. The lowest rates of completed appraisals were 81% for ward staff and 57% for medical staff on Burgess. Psychology and occupational therapy staff appraisal rates were 89% and 100% respectfully. Revalidation rates for medical staff in the service was 100%.
- The service carried out regular audits to assure themselves they were providing safe and quality care but these audits had not identified all the risks found by the Care Quality Commission during the inspection.
- Audits included infection prevention and control, medication management, patient satisfaction, fire safety, the use of seclusion and ligature risks. However, we found it was difficult for staff to evidence a timeline between when they carried out the ward based ligature audit and when the work to remove or modify risks had taken place. Although, a sample of ligature audits from two wards showed that ligature risks identified in 2014 had been mitigated by the service when the next audit was carried out in 2015.

Leadership, morale and staff engagement

- Senior managers did not demonstrate that they had guided staff to fully consider all potential risks on the wards. They did not demonstrate they had sufficient oversight of these concerning issues. For example, senior managers had not used the trust risk register to record issues such as the presence of multiple ligature risks in communal patient areas or the custom and practice of using plastic bags to line bins.

Are services well-led?

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- Ward managers were visible during the day-to-day provision of care and treatment. Ward managers were accessible to their staff. They were not counted in staffing rotas and were available to provide clinical support if staff needed it.
- Staff appeared to be enthusiastic and engaged with their roles. They demonstrated a genuine commitment to providing quality care and treatment for their patients and were keen to talk about their success. Morale across the service was good. Some therapeutic working day staff had left because they did not want to provide a seven-day service but other staff felt the changes to the activity programme were beneficial to both patients and staff. Staff told us the service was a great place to work; and several told us, compared to other organisations they had worked for, the service was the best place they had worked. Staff from all areas of the service told us they loved their jobs and enjoyed working there. Staff were eager to tell us how proud they were of their service.
- Staff told us they received regular supervision. We looked at records and saw this was the case. Staff were able to participate in reflective practice sessions as well as clinical and managerial supervision. Managers used supervision to address areas such as incidents, performance and professional development. They encouraged staff to reflect on their practice and their development needs. The service used a supervision tree, so staff were supervised by someone a grade above them. Staff recorded supervision so managers could check it was taking place. New staff were given a welcome pack to their ward, which included a copy of the team vision.
- There were regular team meetings for sharing information. Newsletters kept staff, patients and others informed of trust and service developments.
- Staff told us they felt able to report incidents and raise concerns without fear of recrimination. They were aware of the whistleblowing procedures and felt confident to use them. Staff made no reports of bullying or harassment to inspectors. The service was willing to provide flexible working patterns for staff when they needed it. Staff told us they felt supported and valued by their immediate line managers and by the service.
- Staff were kept up to date about developments within the trust and the service with newsletters, meetings and team briefings. The service encouraged staff to develop special interests or skills. They were able to share ideas for improvement within the service and were confident senior managers listened to their ideas. They could provide feedback locally or to the trust senior management team. Managers supported staff to be part of the inspection process by placing additional staff on duty during the inspection. Some therapeutic working day staff had left because they did not want to provide a seven-day service but other staff felt the changes to the activity programme were beneficial to both patients and staff.

Commitment to quality improvement and innovation

- The service took part in self and peer reviews with the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services.
- Staff were engaged in research. They were also encouraged to write study and research proposals, which they submitted to the trust for approval. The trust provided support to enable staff to develop special interest projects and to analyses the data they captured.
- The service was keen to develop the staff team and offered opportunities for learning and development.
- The clinical team lead and staff on Danson were keen to further involve patients in developing their care plans. They were about to pilot a digital pen system so patients could directly enter their comments and views on to their care plans which were stored on the trust data base.
- The service had identified areas for environmental improvement. Managers had developed plans for upgrading and redeveloping aspects of the service to meet both patient need and to comply with the revised Mental Health Act 1983 code of practice. Some building work had already been carried out, the trust had approved plans for more building work and some plans were still in the development stage.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Some mental capacity assessments for the purposes of consent to treatment were not robust and did not evidence that the patient had all the information required to make an informed decision. Some patients did not understand the side effects of their treatment or recall their medication but were assessed as having capacity. Some records did not include patient views on their medication treatment plans. This was a breach of Regulation 9 (1) (3) (a) (c) (f) (g) (6).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust had not deployed sufficient staff to ensure their safety on Birchwood. This was a breach of Regulation 18 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not ensure that patients were protected from potential ligature risks in all areas of the ward environment. The seclusion room on Heath did not meet the guidelines set down in the Mental Health Act Code of Practice (2015).

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 12 (1) (2)(a) (b)(d)