Battersea Bridge House

Quality Report

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Date of inspection visit: 7, 8, 22 September 2017
Date of publication: 20/12/2017

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

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

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

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

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

Overall summary

This was an unannounced, focused inspection, where we looked at whether the provider had made the improvements we identified as requiring improvement at our previous inspection in April 2017. We did not rate the service as a result of this inspection. We found the provider had made improvements since the previous inspection and had complied with the warning notice which we served on them in May 2017:

- Safe staffing levels were maintained and staff received regular supervision. Systems were in place to ensure that all incidents within the hospital were reported and that learning from these took place. Staff were now able to access emergency medicines and equipment without delay. Senior leaders were more visible and visited the hospital regularly. Patients were supported to receive treatment for general physical health issues. Systems to monitor side effects and monitor physical health for patients prescribed clozapine were now in place. Medicines were safely stored at the correct temperature.
- A programme to reduce the number of potential ligature anchor points was ongoing and appropriate measures to manage and mitigate risks associated with these were in place. Faults with the secure entry door to the hospital had been addressed. Complaints records were readily accessible and included information on the investigation and outcome of the complaint. The progress of safeguarding alerts was

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monitored. Mental Health Act documentation was available and was maintained in good order. Appropriate arrangements were in place to support patients with their finances and to be able to access these when needed. A review of systems was underway to ensure that changes in risk resulting from incidents were reflected in the patient risk assessment. Improvements to how discussions and decisions made in multidisciplinary meetings were recorded were also underway.

- Patients received regular one to one sessions with their named nurse. Care plans were recovery focused and included plans for discharge. Where patients were nursed in seclusion their care and treatment was regularly reviewed and these reviews were appropriately documented. Staff use of viewing panels in patient bedroom doors now promoted patients' privacy and dignity. Patients were involved in developing their care plans and staff knew how to access interpreting services. For patients with learning difficulties staff took time to work through their care plans with them ensuring they understood and agreed with them. Patients had their rights regularly explained to them and an easy read rights leaflet was available. Opportunities for patients to develop skills and take up vocational training had been developed.

However, further improvements were needed:

- The provider's systems to monitor the safety and performance of the service were not consistent and in some instances not embedded. Further work was needed to strengthen systems to ensure that additional physical health checks immediately following the administration of high dose antipsychotics or olanzapine, were robust, consistent and embedded. We escalated these concerns to the provider during the inspection to ensure the health and wellbeing of the patients. The provider immediately addressed these concerns by carrying out physical health checks on all patients and training the staff on the safe administration of these medications.
- Some incidents that should have been notified to the Care Quality Commission had not been. Systems to learn from incidents at other hospitals managed by the provider were not in place.

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Background to Battersea Bridge House

Battersea Bridge House is a hospital operated by Inmind Healthcare Group, an independent provider of mental health and social care services. Battersea Bridge House provides a low secure inpatient forensic service for men aged 18 years and over with severe mental illness and additional complex behaviour. The service has 22 beds and it provides services across three wards:

- Browning ward is an admission ward and has 10 beds.
- Hardy ward is a step down ward which has six beds.
- Blake ward is a pre discharge ward and has six beds.

Twenty of the 22 beds were occupied during our inspection. All patients receiving care and treatment at the time of our inspection were detained under the Mental Health Act.

The service is registered to provide:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

Battersea Bridge House registered with the CQC in December 2010. There have been five inspections. We previously inspected Battersea Bridge House in April 2017 when we rated the service as 'requires improvement' overall. Following the inspection in April 2017, we rated safe, caring, responsive and well-led as 'requires improvement', and effective as 'inadequate'.

Following the inspection in April 2017, we served the provider with a warning notice on 22 May 2017, and instructed that improvement was required by 14 August 2017. At the last inspection, the hospital did not meet the regulations concerning: Person-centred treatment, Safe care and treatment, Premises and equipment, Complaints, Governance and Staffing.

Our inspection team

The team that inspected the service comprised two CQC inspectors. The team also included two specialist advisors: a pharmacist and a psychiatrist with experience of working in mental health forensic services. The team included an expert by experience. An expert by experience is someone who has experience of using services or of caring for someone using services.

Why we carried out this inspection

We inspected this service to check whether the provider had taken actions to improve following the inspection in April 2017. At this unannounced inspection, we reviewed aspects of the safe, effective, caring, responsive and well-led key questions to identify whether improvements had been made.

The comprehensive inspection carried out in April 2017 identified concerns regarding omissions of care and treatment which put patients at risk of harm. We took enforcement action against the provider and issued a warning notice in relation to Regulation 12 – Safe care and treatment. We required the provider to achieve compliance against this breach by 14 August 2017. We told the provider it must take the following actions to improve its services:

- The provider must ensure that medicines are safely stored at the correct temperatures
- The provider must ensure that patients prescribed high dose antipsychotics have physical health monitored according to guidance
- The provider must ensure that staff proactively assess and provide care planning for potential side effects of constipation with clozapine treatment

Summary of this inspection

- The provider must ensure that staff have access to emergency medicine without delay
- The provider must continue to complete work to remove ligature risks and address the continuing faults of the airlock system in reception
- The provider must ensure that there are sufficient levels of qualified and experienced staff on each shift in line with the hospital's minimum stated staffing levels. The provider must also ensure patients have regular one to one sessions with their named key-worker
- The provider must ensure that nursing and medical reviews of patients in seclusion are carried out and recorded comprehensively
- The provider must ensure that there is effective learning from incidents
- The provider must ensure that patients are able to close viewing panels in their bedrooms
- The provider must ensure that patients' physical health concerns are actively monitored and followed up by staff
- The provider must ensure that patients are involved in the development of their care plans and where this is not possible, the reasons recorded
- The provider must ensure that staff receive regular supervision
- The provider must ensure it meets the needs of patients who require translation from English to another language including access to interpreters and other written information
- The provider must ensure that investigations of complaints are recorded and stored in an accessible format
- The provider must ensure that there are robust systems to monitor the safety and performance of the hospital.

How we carried out this inspection

This was an unannounced, focused inspection with questions asked within the safe, effective, caring, responsive and well-led domains.

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- visited the three wards
- interviewed eight patients
- spoke with eight members of staff including nurses, healthcare assistants and allied health professionals
- met with the clinical director, the governance director and the hospital director
- observed a governance meeting which was a meeting of the senior managers and clinicians of the hospital
- reviewed 11 patient care and treatment records, eight medicines care plans for patients prescribed clozapine and 19 medication records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us that the staff were very good and that they were supported to access to activities in the community regularly. Patients said that they participated in hospital meetings and in the recruitment of staff, which made them feel proud. Patients said that they felt safe at the service, and felt the service had improved.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate safe during this inspection, we found the following improvements:

- Staff now proactively assessed and monitored potential side effects for patients prescribed clozapine. Medicines were now stored safely. The service had purchased two new fridges. Staff were recording checks of fridge temperatures and ensured that medication was safe to use. Staff now had easy access to emergency medication and defibrillators on each ward. The service had improved the learning from incidents, safeguarding and complaints within the service.
- Staff now consistently recorded observations of patients in seclusion. A review of systems was underway to ensure that changes in risk resulting from incidents were reflected in the patient risk assessment. The service had improved its monitoring of safeguarding alerts
- Staff now observed patients using the patients' bedroom viewing panels without affecting patients' privacy and dignity. The service had improved the maintenance of its physical environment. A programme to reduce the number of potential ligature anchor points was ongoing and appropriate measures to manage and mitigate risks associated with these were in place.

However:

- Further work was needed to strengthen systems to ensure that additional physical health checks for patients prescribed high dose antipsychotics or olanzapine, were robust, consistent and embedded.

Are services effective?

We did not rate effective during this inspection, we found the following improvements:

- Staff now received regular supervision. Staff now received specialist training such as seclusion and care planning training.
- Staff now administered medication for patients detained under the Mental Health Act with valid consent to treatment authorisation. Staff explained patients' rights to them monthly.
- Care plans of patients were now recovery focused and patients regularly participated in education and vocational activities in

Summary of this inspection

the community. Patients were supported to receive treatment for general physical health issues. Staff supported patients to see the GP and dentist regularly. Staff supported patients to get regular exercise.

However:

- Staff lacked competence and confidence in assessing patients under the Mental Capacity Act. While the provider took immediate steps to remedy this during the inspection, this needed to be embedded into practice.

Are services caring?

We did not rate caring during this inspection, we found the following improvements:

- Staff now involved patients in the development and review of their care plans, and had clearly documented where patients had refused to participate. Staff now ensured they had regular one to one time with their named patients and recorded this in patients' care records.
- Patients now participated more in the running of the service. Patients were on interview panels for recruitment of staff. Patients now facilitated activities in the service, such as the martial arts and dance sessions. Patients were invited to the monthly governance meetings and patients who had used the service supported the development of the Safewards project.

Are services responsive?

We did not rate responsive during this inspection, we found the following improvements:

- The service had improved its investigation and monitoring of complaints. There were now easy read leaflets on patients' rights under the Mental Health Act and on the side effects of their medication for patients who needed them.
- Staff were now clear on how and when to contact an interpreter for patients that needed them. Staff supported patients to access spiritual support if they asked for it.
- The service now had appropriate arrangements for patients to access funds from their bank account and staff and patients were clear about the system.

Are services well-led?

We did not rate well-led during this inspection, we found the following areas of concern:

Summary of this inspection

- Improvements were needed to the service to embed consistent, robust and effective governance systems.
- The provider had not notified the Care Quality Commission of reportable incidents, such as safeguarding.
- The provider did not have systems in place to ensure that the service learned from incidents at other locations.

However:

- The hospital had now appointed a hospital director. Staff told us that now senior managers from Inmind were visible at the service. The hospital now had established systems to share at provider level information relating to incidents, safeguarding and complaints and these were discussed at bimonthly corporate governance meetings.
- The hospital was now promoting the Safewards project to support patients and staff positive communication.

Detailed findings from this inspection

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.

- Patient records reviewed demonstrated that staff explained to patients their rights every month. Patients had access to information about their rights in an easy read format if they needed it. This had improved since the last inspection.
- Mental Health Act documentation was present in patients' care and treatment records and this was audited by staff each month.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The service was not applying the Mental Capacity Act (MCA) appropriately in cases where there were concerns that a patient did not have capacity to consent to physical health monitoring or treatment. But the hospital had identified this as an area for improvement and measures were put in place during the inspection to address this, however these require embedding into practice.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Forensic inpatient/secure wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are forensic inpatient/secure wards safe?

Safe and clean environment

Safety of the ward layout

- The service continued to have ligature anchor points in the patient environment. A ligature anchor point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ongoing maintenance works were due to complete in September 2017 to remove potential ligature anchor points. All staff were aware of potential ligature anchor points and appropriate measures were in place to manage them, including the use of increased observations for patients assessed as being at risk. Staff completed ligature risk assessments, which were regularly reviewed. The hospital oversaw these measures at monthly managers' meetings.

Maintenance, cleanliness and infection control

- The service had improved the maintenance of its environment. At the previous inspection, we identified maintenance problems with the air-lock door in reception, which did not work properly. At this inspection, we saw this had been repaired. We looked at maintenance records that showed the door had not broken down since the service had repaired it at the time of the last inspection.
- Staff carried out daily, weekly and monthly checks on the environment and escalated concerns where found.

Clinic room and equipment

- The service now had enough medication fridges to ensure medicines were stored safely. At the previous inspection, there was one fridge used to store medicines for all three wards. At this inspection, we saw that the provider had replaced the old fridge with two additional fridges which were in use on the wards.
- The service now had resuscitation equipment and emergency medication which was easily accessible to staff. Our previous inspection had highlighted concerns with access to emergency equipment. At this inspection, this had improved and emergency equipment was available to all three wards. The provider had bought two new defibrillators and emergency medication so that there was now a defibrillator and emergency medication on each ward. All staff we spoke to said they knew where the nearest emergency equipment was.

Safe staffing

Nursing staff

- The service had enough staff to safely care for patients. At the previous inspection, staff told us that wards were sometimes short of staff. At this inspection, we saw that sufficient numbers of staff were rostered on duty and the service was able to deploy staff where they were needed. Patients said that their activities and leave were sometimes delayed because of staffing issues; but no leave or activities had been cancelled. Patients said that they were accessing the community more than they had at the previous inspection.
- The service had improved the frequency of patients receiving one to one sessions with their named nurse. At the last inspection, patients told us that they did not consistently have opportunities to meet their named nurse. At this inspection, we looked at eight care records, we saw staff recorded when they had a one to one with their patients and documented when patients declined to have a one to one. Six patients told us they met with their named nurse every one or two weeks.

- At the previous inspection on Blake and Hardy wards, we observed that there was not always a qualified nurse present in communal areas. At this inspection, we observed that a member of staff was in communal areas whenever patients were present.

Assessing and managing risk to patients and staff

Assessment of patient risk

- At the previous inspection, we saw that staff did not always update a patient's risk assessment following multiple incidents. During this inspection, we reviewed the care and treatment records of 11 patients. We found that for the majority of patients their risk assessments had been updated following incidents, but further improvements were needed. We saw that for two patients their risk assessments had not been updated following incidents. However, details of incidents were readily accessible in patient records and risks were regularly reviewed in team meetings and governance meetings. This meant that where risk assessments had not been updated following incidents, staff were aware of changes in risk and the measures in place to manage and mitigate these.
- The hospital director said that a review of training needs had shown that all staff required training in risk assessment and management. The hospital was reviewing its risk assessment and management systems to address this.

Management of patient risk

Use of restrictive interventions

- The service had improved procedures for recording episodes of seclusion of patients. At the last inspection, seclusion records showed that regular medical and multidisciplinary reviews were not always happening for patients in seclusion. At this inspection, we reviewed seclusion records between 1 August and 7 September 2017 and saw that improvements had been made. Staff now kept records for seclusion in an appropriate manner. All necessary medical and multidisciplinary reviews had been completed and were recorded.

Safeguarding

- The service had taken action to improve safeguarding procedures. At the last inspection, staff did not follow up on safeguarding referrals to clearly track the progress and outcome of the referral. During this inspection, we saw this had improved. Staff had raised three safeguarding alerts during the previous eight weeks and the safeguarding recording tool clearly showed at what stage each safeguarding investigation was currently at.

Medicines management

- While systems to monitor the physical health of patients prescribed high dose antipsychotic medicines, olanzapine and clozapine had been introduced, these were not consistent, embedded or robust. Recently introduced systems to monitor and improve and the administration of medicines also required further embedding.
- Staff stored medication safely. This had improved since the previous inspection, when we found that staff did not monitor the temperature of the medicines fridge regularly. At this inspection, we found that staff monitored and recorded fridge temperatures daily and were aware of the actions to take should temperatures range outside stated parameters.
- The provider had identified that improvements were needed in how medicines were administered and had put in place measures to address this. We saw that the managers' meeting and governance meeting in September 2017 had discussed medicines issues that included authorisation and completion of medicines administration records. As a result, training was provided to nurses regarding medicines administration and arrangements were in place for a pharmacist to conduct weekly audits and provide additional training for staff as required. The service planned to continue to review the outcomes of medicines administration audits and medicines errors regularly at governance meetings. The provider's medicines administration policy had been reviewed and this information was cascaded to staff.
- At the previous inspection, we found that staff did not complete required physical health checks and observations for patients who were at risk of developing physical health problems as a result of high doses of antipsychotic medication. We also found that for patients prescribed olanzapine depot injections, staff had not taken physical observations after administering the medication as required in the product specification. Since the previous inspection, the provider had updated its medication policy to include guidance for staff on monitoring physical health where high doses of antipsychotic medicines were prescribed. The service

had arranged cover to ensure a physical health lead nurse was available to hold weekly clinics during the regular post-holder's absence. However, during this inspection we saw that systems to identify and monitor patients at risk of physical health issues as a result of receiving high dose antipsychotic medicines or olanzapine needed further strengthening.

- During this inspection, we reviewed the care and treatment records of six patients who were receiving high doses of antipsychotic medication or were prescribed olanzapine medication. Staff had regularly completed the physical health checks and observations for three of the six patients whose records we looked at. We saw that one patient had not been identified by staff as being prescribed high dose antipsychotic medicines and required physical health checks had not been completed. We also saw that where two patients had declined physical health observations this was not recorded. Staff told us when patients declined observations they did check on them regularly, but this was also not recorded. Some patients had additional physical health checks undertaken by the GP because of the medicines they were prescribed. We saw that these results were not routinely checked or followed through. Our findings regarding specific patients were escalated at the time of the inspection and the service took immediate steps to address these. In addition, the service immediately reviewed all patients to ensure all patients who receiving high dose antipsychotics were identified.
- The provider had improved the management of side effects for patients on clozapine. At the last inspection, staff had not given patients on clozapine medication information on the side effects of the medication and did not develop a care plan to assess and monitor these. During this inspection, we looked at the medicines care plans for eight patients prescribed clozapine medication. Each had received information on its side effects. Appropriate care plans were in place and staff were proactive in monitoring and managing the side effects of this medication. We spoke to staff who were clear about how to monitor physical health signs in patients who received clozapine.

Reporting incidents and learning from when things go wrong

- The provider had improved its system for recording incidents. At the last inspection, we found that there was not an effective and cohesive system to record incidents. During this inspection, we found the system for recording incidents had improved. An incident log book was maintained by each ward. A copy of the incident report was also placed in the relevant patient care and treatment record next to the patient's risk assessment. There was also a separate patient incident folder which had copies of all the patients' incident forms. Staff were aware of the systems to record incidents and told us that they were able to readily check which patients had been involved in incidents. We found that the incident log books corresponded with the incident folder, and corroborated the safeguarding alerts that had been made during the previous eight weeks.
- The provider had improved the way that staff learned from incidents at the service. At the last inspection, there was no evidence that the provider gave feedback from incidents both internal and external to the service to staff, and learning from incidents was not discussed at regular team meetings. During this inspection, we saw team meeting and governance meeting minutes which showed that learning from complaints, safeguarding and incidents were discussed at each meeting. There was also a lessons learned log in the minutes which showed learning from incidents was shared. Changes and lessons learned were shared at the service governance meeting and at team meetings. These lessons learned were also emailed to staff members. Recent examples of lessons learned included the need for improved and consistent communication between staff and patients and the need to record shift planning meetings.
- There were systems in place to notify senior managers at Inmind about complaints, safeguarding and incidents. These were discussed at governance meetings at Inmind and proposed changes and learning were feedback to the hospital. However, systems to share learning from other locations within Inmind were not robust or embedded. This had not improved since the previous inspection. Staff were not able to tell us how learning from other locations was shared with them, or changes that had been made locally as a result of this learning.

Are forensic inpatient/secure wards effective?

Forensic inpatient/secure wards

(for example, treatment is effective)

Assessment of needs and planning of care

- Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission. Staff developed care plans that met the needs identified during assessment and updated these regularly.
- We saw that care planning had improved since the previous inspection. Care plans now included a recovery focus and set goals to support and prepare patients for discharge to the community. We looked at 11 care plans and found that they had different sections to cover different areas of the patients' lives, for example health and well-being, substance misuse, risk of violence and managing money. Care plans were regularly updated and either included the patients' voice or indicated that the patient did not want to be involved. However, two of the care plans we looked at did not reflect the patients' views.
- At the previous inspection, we found that systems to identify, monitor and address patients' general physical health were not robust or embedded. During this inspection, we saw this had improved. The service registered patients with a local general practitioner (GP) who visited the hospital each week. In addition, the service had appointed a physical health nurse who held weekly clinics. For five patients where general physical health issues were identified, we saw that staff had taken appropriate action to ensure these were monitored and addressed. Patients told us that since the last inspection they had more confidence in staffs' ability to meet their physical health needs.

Best practice in treatment and care

- The provider had improved the supervision of staff. At the last inspection, supervision records showed that on average 60% of staff had received supervision during the previous three months. At this inspection, supervision records showed that staff were receiving supervision more regularly; 94% of staff had supervision at least every two months during the previous four months. We looked at two sets of supervision notes and found that they addressed clinical practice as well as management issues. The service had introduced a standardised template for use in supervision which covered areas such as personal development, time management, mandatory training and reflective practice.
- The provider had improved the availability of specialised training for staff. At the last inspection, staff told us that there were limited opportunities for specialist training. At this inspection, we found that staff had recently had training in care planning and seclusion monitoring.
- Staff supported patients to access community health services for routine checks. Five patients told us that staff supported them to see the dentist regularly.
- The staff supported patients to live healthier lives. Patients were able to access regular exercise which was important as many patients were on medication which put them at risk of gaining weight. Of the 20 patients at the service, 11 had a body mass index of over 25, which indicated they were overweight. Patients told us that they went to the gym regularly and were involved in dance and martial arts sessions, which were held weekly. Staff also took patients with leave for weekly walks in the community. Staff used these opportunities to engage patients in care planning or psychological support, patients called these sessions 'walk and talk'.
- The hospital had recently introduced the Safewards project which aimed to improve communication between staff and patients. The Safewards project was developed in conjunction with patients who had been discharged from the service.

Multidisciplinary and inter-agency team work

- Staff contributed to regular multidisciplinary team (MDT) meetings and patients were reviewed fortnightly by the MDT. Recent audits completed by the service had identified that improvements were needed as to how these discussions were recorded. Following a governance meeting in August 2017, the provider was introducing a system for patient records to be updated 'live' during the MDT discussion.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Forensic inpatient/secure wards

- The patient records reviewed demonstrated that staff explained to patients their rights every month. Patients had access to information about their rights in an easy read format if they needed it. This had improved since the last inspection.
- Mental Health Act documentation was present in patients' care and treatment records and this was audited by staff each month.

Good practice in applying the Mental Capacity Act

- The service was not applying the Mental Capacity Act (MCA) appropriately in cases where there were concerns that a patient did not have capacity to consent to physical health monitoring or treatment. The hospital had identified this as an area for improvement and measures were put in place during the inspection to address this.
- The service identified a patient as not having capacity to consent to physical health monitoring or treatment. The service had not completed a capacity assessment for this patient. This was escalated during the inspection and the service responded by recruiting interim staff with training and competence in assessing patients under the MCA.

Are forensic inpatient/secure wards caring?

Involvement of care

Involvement of patients

- Patients were given a welcome pack when they first arrived on the ward. Staff supported them to meet different professionals and other patients. Staff also supported patients on admission by giving them a tour of the facilities.
- Patient involvement at the service had improved. At the last inspection, patient care plans showed little patient involvement. At this inspection, we saw where staff had recorded their attempts to engage patients, but some patients had declined. Three patients told us that they were involved in the development of their care plans.
- Patients were invited to the monthly governance meetings at the hospital. Governance meetings included the senior clinicians and managers at the hospital and covered incidents, staffing levels, safeguarding and complaints. We observed patient involvement at these meetings.
- Patients were invited to help interview staff for the service. One patient we spoke to said that they enjoyed the opportunity and had written nine of the interview questions in consultation with the other patients.
- Patients were supported to facilitate some of the activities themselves. Two patients led the weekly martial arts and dance sessions.
- Patients who had left the service had been involved in the development of the Safewards project, which had recently started at the service.

Are forensic inpatient/secure wards responsive to people's needs? (for example, to feedback?)

The facilities promote recovery, comfort, dignity and confidentiality

- There had been improvements in how staff promoted patient privacy and dignity since the previous inspection. At the previous inspection, staff left viewing panels in patients' bedrooms doors continuously open and patients were not able to close these. During this inspection, this had improved. We spoke with eight patients who all said that staff had asked them whether they preferred to have their viewing panel kept open or closed. A notice on the outside of each patient's bedroom door stated whether the viewing panel should be kept open or closed. Staff were still able to open viewing panels when they did observations.

Patients' engagement with the wider community

- The service had improved its system for managing patients' finances. At the last inspection, the system for managing finances for patients, who were not able to access leave, was unclear. At this inspection, all patients said they had access to their money and that there were clear systems to manage this. Patients' bank cards were securely held and returned to them prior to leave. For patients who did not have leave, the service provided

them with money to buy things like takeaway food. This money was reimbursed when the patients were granted leave. Staff supported patients to get a bank card if they did not have one already.
- Staff supported patients to access the community and develop vocational skills. Patients had access to a recovery college and three patients were enrolled in this. Staff supported patients to go to a gardening project every week. There was also a music production activity available for patients.

Meeting the needs of all people who use the service

- The service had improved the availability of interpreters. At the last inspection, there was a patient who did not have English as a first language who did not have adequate access to an interpreter. At this inspection, while there were no patients who required an interpreter, all staff were clear on how to access an interpreter if needed. Information on how to access interpreting services was clearly displayed in all wards.
- At the last inspection, we found that staff had not met the specific needs of patients with learning disabilities as care plans and other documents were not available in an easy read format. During this inspection, we saw that this had improved. Staff spent time with patients with a learning disability talking through their care plans in a way that made them accessible and understandable to the patient.
- Staff supported patients to access spiritual support if they asked for it. There were notices displayed in the wards which explained who to contact for access to spiritual support.

Listening to and learning from concerns and complaints

- The service had improved its recording and handling of complaints. At the last inspection, staff could not access complaints investigation records easily. Staff did not clearly record the investigation completed for each complaint or its outcome. At this inspection, we saw this had improved. Staff knew how to handle complaints and complaints records were easily accessible. These records included the investigation and outcome of each complaint.
- Patients knew how to complain or raise concerns. Three patients we spoke with had complained. They told us there concerns had been addressed promptly, that they had received feedback and were satisfied with the outcome of their complaint.
- We saw evidence that learning from complaints was discussed at governance and team meetings.

Are forensic inpatient/secure wards well-led?

Culture

- There was better visibility of senior managers at the hospital. At the last inspection, staff did not feel that senior managers at a corporate level were visible and three members of staff told us they did not feel engaged with the organisation as a whole. At this inspection, staff said that they had seen the senior managers often and that they had talked to them regularly. The Group Operations Director said that they were at the hospital every week.
- A hospital director had been appointed to the service and was in the process of registering with CQC as the registered manager.

Governance

- Further improvements were needed to ensure that effective, robust systems were developed and embedded to consistently promote the safety and wellbeing of patients.
- Governance systems to identify, monitor and manage physical health checks did not ensure that patients were protected from the physical health risks associated with their treatment. This shortfall was in part because of a lack of oversight of the responsible clinician at the time of the inspection. As a result of the concerns escalated during the inspection, the provider took action to suspend this clinician and made a suitable interim appointment while the matter was investigated. The provider also put arrangements in place for appropriate clinical oversight and management of this interim appointment. Immediate action was also taken by the provider to address individual patients' physical health concerns.
- Other governance systems identified during the inspection that required strengthening included staff competence and confidence in applying the Mental

Capacity Act, medicines administration, updating of risk assessments following incidents and learning from incidents across different locations managed by the provider. These were areas the provider had identified as needing improving and plans to improve these were in place.

- However, there were effective systems in place to ensure that wards were clean and safe, that sufficient staff were on duty and that staff received regular, good quality supervision. Effective systems were also in place to ensure that patients were assessed and treated well, that beds were managed and discharges planned. The majority of issues from the previous inspection had been addressed and improvements made, including incident reporting, safeguarding and access to emergency medicines and equipment. An ongoing programme of works was underway to remove ligature anchor points

Information Management

- The provider had not notified the Care Quality Commission of some incidents, as required. We discussed this with the hospital director, who advised that they were not aware of this requirement and would in future ensure that all required notifications were made.

Commitment to quality improvement and innovation

- The service had recently started the Safewards project. This project was developed by staff and patients who had been discharged by the service. This project aimed to improve communication between staff and patients and promote positive relationships, reduce the need for restraint, and better support the patients' well-being.
- The hospital was not participating in accreditation schemes relevant to the service at the time of this inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all systems used to ensure the safety and wellbeing of patients and monitor the performance of the hospital are consistent, robust and embedded.
- The provider must ensure that it submits the necessary notifications as required by the Care Quality Commission Registration regulations 2009.

Action the provider SHOULD take to improve

- The provider should ensure that works to reduce the number of ligature anchor points within its premises continues and is completed in line with its action plan.
- The provider should ensure that plans to improve risk assessment and management and the recording of multidisciplinary discussions are implemented.
- The provider should ensure that learning from incidents at other locations is shared with the service.

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 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated effectively to assess, monitor and improve the quality and safety of the service provided.** The provider did not ensure that robust, consistent systems were in place to promote the safety and wellbeing of patients prescribed high dose antipsychotic medicines or olanzapine. **This was a breach of Regulation 17 (1)(2)(a)(b)**

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 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not ensure that incidents that must be notified to the Care Quality Commission had been. **This was a breach of Regulation 18 (2)**