Ansel Clinic Nottingham

Quality Report

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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

Ratings

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

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.

Summary of findings

Overall summary

We rated the Ansel Clinic Nottingham as requires improvement because:

- Clinic room equipment on Acorn ward was not consistently checked and some equipment had not been calibrated.
- Not all electrical devices demonstrated safety checks were undertaken.
- Staff had not always followed correct procedures for seclusion.
- Cambian Mental Health Act (MHA) policies did not reflect the changes to the Code of Practice in April 2015.

However,

- Managers undertook an assessment of ligature risks annually and then took appropriate steps to reduce risk. They participated in regular local and regional governance meetings. Staff knew who their managers were.
- Staff had access to mandatory training and additional specialist training to ensure they were suitably skilled and qualified. Supervision of staff took place frequently and all staff had received an appraisal in the 12 months prior to our inspection. All support workers worked towards the care certificate.
- There were effective working relationships with teams outside of the organisation such as local authority safeguarding teams and GPs as well as local voluntary organisations that supported patients to secure employment in the local community.
- Staff used a recognised outcome measure to measure recovery.
- Patients had access to psychological therapies and National Institute for Health and Care Excellence (NICE) guidance was informing care planning. A full range of mental health disciplines had input to patient care.
- Patients' care records contained up to date, personalised, holistic, recovery-oriented care plans and demonstrated comprehensive and timely assessments following admission. They showed patients being involved in their care planning and risk assessments. Patients told us staff were caring and provided them with practical and emotional support. We saw staff treating patients kindly and with compassion. Staff had undertaken physical health examinations of patients on admission to the service.
- Patients could give feedback about the service in weekly community meetings and in patient surveys. Patients had advance statements in place detailing their preferences for care and treatment.
- Patients were able to personalise their bedrooms to reflect their taste and preference and could make drinks and snacks 24 hours a day if they chose to do so. There was access to a full range of rooms to support treatment and care.
- The hospital was fully accessible for people with disabilities.
- Rotas demonstrated adequate safe staffing levels.
- There were no delayed discharges from the service.

Summary of findings

Contents

Requires improvement

Ansel Clinic Nottingham

Services we looked at

Forensic inpatient/secure wards

Summary of this inspection

Background to Ansel Clinic Nottingham

- The Ansel Clinic Nottingham is a specialist low secure mental health rehabilitation service for men with a personality disorder, who also present with complex mental health needs and challenging behaviours. All patients are detained under the Mental Health Act.
- There was a registered manager on the days of our inspection.
- The Ansel Clinic is registered to provide: Assessment or medical treatment for persons detained under the Mental Health Act 1983; Diagnostic and screening procedures and Treatment of disease, disorder or injury.
- There were two wards Ancaria with 12 beds and Acorn also with 12 beds. Both wards are male only.
- We have previously inspected this hospital on 9, 10 October 2012, 8 October 2013, 6 March 2013 and 9 July 2015.
- Requirement notices were issued after the last inspection in regard to Regulation 9 Health and Social care (HSCA) 2008 (Regulated Activities) Regulations 2014 Person centred care and Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Premises and equipment. The requirements under these notices were met on this inspection but other requirement notices have been issued with this report.
- Between 14 May 2014 and 09 July 2015 there had been three Mental Health Act Review visits to Ansel Clinic Nottingham.

Our inspection team

Team leader: Nick Warren

The team that inspected the service comprised two CQC inspectors and two specialist advisors, one who was a consultant clinical psychologist and the other a secure hospital nurse manager.

Why we carried out this inspection

We inspected this 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 we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited two wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with three carers
- spoke with the registered manager and director of operations who was the nominated individual for the service

Summary of this inspection

- spoke with 12 other staff members; including nurses, support workers, a psychologist, a Mental Health Act administrator and social worker, we were unable to speak to any medical staff on the day
- spoke with an independent advocate
- attended and observed a multidisciplinary team morning meeting and one multi-disciplinary team meeting
- attended and observed a reflective practice meeting
- collected feedback from eight patients using comment cards
- reviewed six care and treatment records of patients
- reviewed 12 medicine charts
- carried out a specific check of the medicines management on two wards
- reviewed the findings from a staff survey and a patient survey
- 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 staff were kind and caring and we observed this. They told us they were involved in their care plans and had advance statements. Care records demonstrated this to be the case.

Patients told us they sometimes felt unsafe at the hospital because of other patients being loud and verbally aggressive although no patients had come to any actual harm from other patients.

Patients told us there was a good selection of activities available to them including at weekends but told us sometimes scheduled activities would be delayed due to insufficient staff particularly when staff were facilitating Section 17 leave for other patients. Some patients told us they do not like staff to wear their uniforms visibly when taking them out on Section 17 leave.

Carers told us they thought the Ansel Hospital was very good and had helped their relatives make significant improvements. They knew how to complain and told us that when they had complained their concerns were listened to and dealt with in a timely fashion.

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?

Requires improvement

We rated safe as requires improvement because:

- Checks on emergency equipment and medicine fridge temperatures on Acorn ward had not been consistently undertaken. Equipment to measure temperature, pulse and blood pressure had not been calibrated.
- Electrical safety stickers were not present on a television and a kettle. It was therefore not clear if these items had been appropriately safety tested.

However,

- Managers undertook an assessment of ligature risks annually and then used to minimise risk on identified ligature points. Ligature points are fixtures to which people might tie something to strangle themselves.
- Managers could cover staffing short-falls with temporary staff from their own bank with minimum use of agency staff.
- Temporary staff were oriented to the ward and provided with a structured induction to allow them to work safely with the patients.
- All care records we reviewed demonstrated risk assessments undertaken by staff for each patient upon admission to the service.
- Staff used observation to reduce potential risks such as ligature risks.
- Staff trained in safeguarding knew how to make a safeguarding alert and did this when appropriate.
- Staff recorded and reported all incidents appropriately.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Mental Health Act (MHA) policies did not reflect the changes to the Code of Practice in April 2015.
- One patient had a T2 on his medicine chart and it should have been a T3. These are forms that show whether a patient has capacity to understand his medication and if not whether a second opinion was undertaken with regard to giving medication without the patients consent. It is important a patient that is not able to give consent has this legally reviewed so the medication can be given lawfully.

Summary of this inspection

- Staff compliance with equality and diversity training was only 40%.

However,

- All care records we reviewed demonstrated comprehensive and timely assessments completed after admission.
- Staff had undertaken physical health examinations of patients on admission to the service. There was ongoing monitoring of physical health issues throughout the admission.
- Care records contained up to date, personalised, holistic, recovery-oriented care plans.
- Staff used a recognised outcome measure called the health of the nation outcome scales.
- Staff were suitably experienced and qualified for their role. All support workers worked towards the care certificate.
- A full range of mental health disciplines had input to patient care.
- There were effective working relationships with teams outside of the organisation such as local authority safeguarding teams and GPs.

Staff had good relationships with local voluntary organisations that supported patients to secure employment in the local community.

Are services caring?

Good

We rated caring as good because:

- Patients told us staff were caring and provided them with practical and emotional support and we observed staff were kind and compassionate.
- Patients' care records demonstrated patients being involved in their care planning and risk assessments.
- Patients could access advocacy services.
- Patients could give feedback about the service in weekly community meetings and in patient surveys.
- Patients were involved in interview processes for new staff.
- Patients had advance statements in place detailing their preferences for care and treatment.

However,

- Three out of five patients told us they did not like staff escorting them on Section 17 leave while wearing their uniforms. The patients felt this compromised their dignity and confidentiality.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- There were no delayed discharges from the service.
- Beds were available at the hospital for people living in the local area.
- Patients had access to a full range of rooms to support treatment and care.
- The hospital was fully accessible for people with disabilities.
- Staff received feedback on the outcome of investigations of complaints.
- Patients could make drinks and snacks 24 hours a day if they chose to do so.
- Patients were able to personalise their bedrooms to reflect their taste and preference.
- Spiritual support could be provided by local spiritual leaders.

Are services well-led?

Good

We rated well-led as good because:

- Staff knew who the most senior managers were and told us some of these managers have visited the wards.
- Staff had received all required mandatory training.
- Staff had been appraised and had regular access to supervision and appraisal.
- Rotas demonstrated set and safe staffing levels.
- Staff learnt from complaints and patient feedback.
- Staff had opportunities for leadership development.
- Managers participated in regular local and regional governance meetings.
- Staff sickness absence levels were consistently below the national average of 4.4%.
- Management had been working hard to put positive action plans in place to make improvements since our last inspection.

However,

- There was not always evidence of learning from individual patients' risk incidents.
- Some staff were experiencing challenges in assimilating the changes introduced by Cambian.

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.

- Staff compliance with mental health act (MHA 1983 and amended 1987) training was 100%.
- Staff were trained in and had a good understanding of the MHA, the Code of Practice and the guiding principles.
- Consent to treatment and capacity requirements were adhered to and copies of the authorised medication treatment certificates (ie T2 & T3) were attached to medication charts so staff were aware of the legal authority under which they were administrating medication
- Patients had their rights under the MHA explained to them on admission and routinely thereafter.
- Administrative support and legal advice on implementation of the MHA and its code of practice was available from the MHA administrator.
- Detention paperwork was correctly filled in, up to date and stored appropriately.
- Cambian services had not updated their mental health act policies in line with the revised mental health act code of practice (April 2015). The in house mental health act administrator was aware of this and had ensured local training had been updated. This included producing a staff information booklet titled 'Code of practice update' April 2016.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were 100% compliant with mental capacity act (MCA) training.
- Staff were trained in and had a good understanding of MCA 2005, in particular the five statutory principles.
- All patients had been appropriately assessed for capacity.
- The provider had a policy on MCA to guide staff.
- Staff understood and where appropriate worked within the MCA definition of restraint.
- No deprivation of liberty safeguard applications were made in the six months between September 2015 and February 2016

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- Access to the building was controlled by reception staff through a secure air-lock. Restricted items such as car keys and mobile phones had to be stored securely in a locker in the reception area before accessing the ward. However, reception staff did not initially ask that our inspector team handed in keys or mobile phones to comply with the security protocol. Reception staff eventually asked our inspectors to comply with the protocol at lunch time.
- CCTV cameras were in operation in all areas of the hospital apart from the ward lounges, patients' bedrooms and bathrooms. The CCTV monitors were in the reception area and were not used as a means to mitigate any potential risks such as ligature risks in the environment but as evidence to support any reviews of incidents.
- There were two wards at Ansel clinic and each ward had the same layout. There were blind spots on corridors on both wards. These were mitigated by the use of staff observation, and controlling access to shared spaces such as therapy rooms by locking the rooms when not in use.
- Managers undertook an assessment of potential ligature risks annually. The assessment undertaken in October 2015 highlighted a number of potential ligature risks. Most of these had been graded as low risk and were mitigated by staff observations. Some had been graded as medium risk. The medium risks identified were in areas of the wards such as therapy rooms only accessed by patients with staff supervision. Actions had been undertaken to reduce some risks highlighted.
- Clinic rooms were fully equipped with an examination couch, scales, emergency medicines and related emergency equipment such as a defibrillator and oxygen cylinders. We saw logs demonstrating daily checks of oxygen cylinders and the defibrillator being undertaken. However, on Acorn ward we found evidence of checks on the defibrillator being missed on 13 dates in January 2016, five dates in February 2016 and two dates in March 2016. In addition, medicine fridge temperature checks were missed on six dates in January 2016 and one date in March 2016. There was no evidence of calibration of equipment for measuring blood pressure and pulse or temperature. It is important to regularly calibrate this equipment to ensure accurate measurements of physical observations.
- Ansel Clinic had been awarded a Food Hygiene Rating of five (Very Good) by Nottingham City Council on 13 August 2014.
- Ancaria ward had seclusion facilities. The seclusion facilities were compliant with standards set out in chapter 26 of the Mental Health Act Code of Practice (2015). However, access to toilet facilities had to be facilitated by staff.
- Both wards were clean and furnished well.
- Staff adhered to infection control principles including handwashing. However, an alcohol hand-gel dispenser in the reception area was empty when we arrived. There was a second dispenser available and this had hand-gel in. The empty dispenser had been re-filled later in the day. Other dispensers on the ward areas contained hand-gel.

- Electrical equipment had stickers showing dates of safety checks and were up to date. However, a television and a kettle did not have any evidence of these safety checks. A clinic fridge had a safety check sticker of August 2014. Ansel clinic did have a Certificate of Electrical Appliance testing valid until February 2017 but we were unable to establish on our inspection if this included the appliances we found.
- Cleaning records were up to date and demonstrated regular cleaning of the environment.
- Staff carried electronic personal alarms. In addition, nurse call alarms were available in all patient areas.

Safe staffing

- Senior managers at the provider had set staffing levels. No recognised safer staffing tool had been used to support calculation of the staffing complement and numbers had been calculated by task orientation. The registered manager had recently reviewed staffing levels and was in the process of recruiting a further two ward managers.
- The total establishment numbers of registered nurses was 13. Total establishment numbers of support workers was 36.
- Nursing staff worked 12 hour shifts. The staffing complement for both wards on day shifts was two registered nurse and nine support workers. On night shifts the staffing complement was set at one registered nurse and two support workers for each ward. Managers were available to cover wards when needed Monday to Friday such as ward rounds and multidisciplinary meetings.
- Two staff told us set staffing numbers on night shifts over the weekend prior to our inspection did not meet set staffing levels. Insufficient staff would not have been able to safely manage any incident of violence and aggression. However, we did not find any evidence from rotas to support this claim. There were no incident reporting and recording forms completed to report unsafe staffing levels over the weekend in question.
- Staff turnover as of February 2016 was 5% with vacancies at 14.5%.
- The provider did not return any data regarding staff sickness but rotas demonstrated sickness absence occurring.
- Managers could cover staffing short-falls with temporary staff. We found evidence of temporary staff being used to cover short-falls in all instances we looked at apart from the night shifts mentioned above.
- The provider returned data to show six shifts had been covered by temporary staff in the period 2 November 2016 to 7 February 2016. However, rotas for 8 February to 6 March 2016 showed there were 34 shifts where temporary staff had been recruited to cover registered nurse vacancies and 32 had been recruited to cover support worker vacancies.
- Temporary staff used were regular bank staff. Agency staff were rarely used. Temporary staff were oriented to the ward and provided with a structured induction to allow them to work safely with the patients.
- Registered nurses were not always present in communal areas of the ward. There was one registered nurse on duty on each shift and when they had to dispense medicines or attend multidisciplinary team meetings they could not be present. We were told senior managers were available to cover these periods. Senior support workers were present in communal areas at all times during our inspection. We could not find evidence to support this had a detrimental effect on patients.
- Care records demonstrated patients had daily one to one time with nursing staff.
- Staff and patients told us Section 17 leave was rarely cancelled due to staffing shortages.
- Staff and patients told us activities were sometimes cancelled or postponed due to staffing shortages. Staff and patients told us staffing shortages frequently arose when staff were facilitating escorted leave.
- Medical cover was provided by the psychiatrist during business hours (Monday – Friday, 9 – 5). Out of hours cover was provided by the on-call duty psychiatrist who was able to attend the hospital within an hour if called. Additional medical cover was available from the GP service and, in the case of an emergency, from the local accident and emergency department.

Assessing and managing risk to patients and staff

- Seclusion was used on four occasions in the time period September 2015 to February 2016
- Seclusion records were accurate, correctly completed and securely stored with the patients' care records.
- A risk incident recorded and reported on April 11 2016 reflected a patient had been asked to go to the seclusion room voluntarily. The patient had declined

and assaulted staff. Staff physically restrained him and placed him in seclusion. The Mental Health Act Code of Practice (MHA CoP) 2015 is clear seclusion should be a last resort when all other interventions such as de-escalation have failed. Requesting a patient to put themselves into seclusion is not supported in the MHA CoP.

- A risk incident recorded and reported on April 8 2016 reflected a patient being found to have taken a mobile phone into the seclusion room when staff secluded him. It was one hour and 50 minutes before staff noticed the patient had the mobile phone. The patient self-harmed with a piece broken off the mobile phone. All patients should be searched prior to the seclusion room being locked and the patient being formally secluded. Searching patients reduces the potential for patients to have access to items which could be used to harm the self or others whilst in seclusion.
- There was no recorded use of long term segregation in the time period September 2015 to February 2016.
- There were 62 incidents of physical restraint in the time period September 2015 to February 2016. The provider had not collated any data regarding how many different patients had been subject to restraint. The provider had not provided data regarding which ward had the highest number of restraints. However, we separately requested data relating to recorded and reported risk incidents for the time period 2 February 2016 to 26 April 2016. This requested data showed a total of 120 recorded and reported risk incidents. Of these, 118 had taken place at the hospital and of these 104 had taken place on Ancaria ward. Therefore, it seems likely most physical restraints would have taken place on Ancaria ward.
- There was one recorded use of prone restraint in the time period September 2015 to February 2016.
- There was no recorded use of rapid tranquillisation in the time period September 2015 to February 2016.
- Staff and patients told us de-escalation was used wherever possible and restraint was only used if de-escalation had failed. Eighty two of the 118 risk incidents reported and recorded in the time period 2 February 2016 to 26 April 2016 related to physical violence towards staff. The remainder of the incidents related to self-harm, absconsion, escape, substance misuse and verbal abuse.
- National Operational governance minutes from 17 November 2015 reflected discussion around changing the provider's training package for physical interventions. The minutes stated NHS providers did not support the physical interventions used by the provider. All providers are expected to seek to avoid the use of prone restraint and to reduce their use of all restrictive interventions wherever possible (Mental Health Act Code of Practice Ch. 26 2015, 'Positive and Safe' DH 2014 and National Institute of Health and Care excellence (NICE) guideline NG10).
- We reviewed six sets of care records across both wards. All care records we reviewed demonstrated risk assessments being undertaken by staff for each patient upon admission to the service.
- Staff used recognised risk assessment tools such as short term assessment of risk for treatment (START) and historical and clinical risk management 20 version 3 (HCR-20 V3) to assess risk. The HCR-20 V3 is most useful as an evidence-based guideline that aids clinical formulations of violence risk, structures clinical judgements and informs management interventions (Douglas et al., 2008; Lewis & Doyle, 2009). This risk assessment is useful in this type of low secure environment where patients present with more challenging behaviour than on an acute or rehabilitation unit.
- Psychologists provided a formulation (an understanding of the patient's difficulties) based on the HCR20v3. The formulation would identify the function of the identified risk behaviour.
- Patients had positive behaviour support (PBS) plans to address identified risks. Positive behaviour support plans are individualised plans which provide primary, secondary and tertiary strategies to address risks with the aim of avoiding risk incidents by intervening early in the least restrictive way. PBS plans are fundamentally rooted in person centred values, aiming to enhance community presence, increasing personal skills and competence and placing emphasis on respect for the individual being supported. The PBS plans we looked at the showed careful consideration to patient involement
- Blanket restrictions such as locked doors at reception were only used when justified by the potential risk.
- Staff used observation to reduce potential risks such as ligature risks. There was a policy to support observation and we saw staff followed this.
- Staff searched patients when they returned from Section 17 leave, prior to seclusion and if they had good reason to suspect a patient may have risk items on their person. There was a policy to support searching of patients. The

Requires improvement

Forensic inpatient/secure wards

hospital provided training for staff in both personal and environmental search techniques. However, we found evidence of an incident where staff had not found and removed a mobile phone from a patient in seclusion.

- Staff were trained in safeguarding, knew how to make a safeguarding alert and did this when appropriate. We received one safeguarding alert and 15 safeguarding concerns between 29 January 2014 and 13 January 2016 regarding Ansel Clinic Nottingham. As of 05 February 2016, all safeguarding alerts and concerns were closed.
- There were safe procedures for children visiting the ward.
- Staff managed and stored medicines safely at the hospital. Staff correctly reported and recorded medicine errors. Medicine charts we reviewed were correctly written and contained all the appropriate signatures.

Track record on safety

- The hospital reported eight serious incidents occurring between 04 October 2015 and 28 January 2016. Two of the eight incidents were unexpected or avoidable death or severe harm of one or more patients, staff or members of the public, one related to allegations, or incidents, of physical abuse and sexual assault or abuse, three incidents related to absconsion from care, and two incidents of patients being in possession of illegal material.
- There had been no never-events in the 12 months prior to our inspection. Never Events are serious incidents that are wholly preventable.

Reporting incidents and learning from when things go wrong

- Staff were able to tell us how they recorded and reported risk incidents. They knew to report all risk incidents and near misses.
- Staff recorded and reported all incidents appropriately.
- Staff and patients told us staff were open and honest and explained to patients when things went wrong.
- Staff received feedback from the investigation of incidents in staff meetings and in supervision. However, there was little evidence of learning from when things go wrong. Reviewing recorded and reported incidents from the time period 2 February 2016 to 26 April 2016 demonstrated the same type of incident occurring repeatedly without any changes to practice or individual risk management. For example, one patient had broken crockery on three separate occasions and harmed himself with the broken pieces.
- Local Clinical Governance Meeting recorded that incidents had been discussed but it was not clear what actions were taken or how information was fed back to staff.
- Staff were provided with de-brief and support by psychologists in the service following serious incidents. Patients were also seen after any such incident that affected them and offered support.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We reviewed six sets of care records and 12 medicine charts. All care records we reviewed demonstrated comprehensive and timely assessments completed after admission.
- Staff had undertaken physical health examinations of patients on admission to the service. There was ongoing monitoring of physical health issues throughout the admission.
- Care records contained up to date, personalised, holistic, recovery-oriented care plans.
- All information needed to deliver care was stored securely and available to staff when they needed it and in an accessible form.

Best practice in treatment and care

- We reviewed 12 medicine charts. Ten demonstrated adherence to national institute of health and care excellence (NICE) guidance for prescribing medicines.
- The psychologist provided psychological therapies recommended by the national institute of health and care excellence (NICE). One of the assessment tools used was CIRCLE, which stands for Circumplex of Interpersonal Relationships in Closed Living Environments. It gives a measure of interpersonal

characteristics of adults in secure settings and is based on staff observation. This means individuals who were unwilling or unable to complete a conventional self-report measure may still be assessed.
- Patients had good access to physical healthcare. They were registered with a GP and were referred to specialist services as required in a timely fashion.
- Staff used a recognised outcome measure called the health of the nation outcome scales to monitor patient's improvement.
- Staff undertook clinical audits such as audits of care records and medicine charts. This helped develop action plans to improve practise.

Skilled staff to deliver care

- A full range of mental health disciplines had input to patient care. The multidisciplinary team comprised a psychiatrist, a psychologist, an occupational therapist, a social worker and registered nurses.
- Staff were suitably experienced and qualified for their role. All support workers worked towards the care certificate.
- Staff received an induction before starting work with the patients. The induction provided mandatory training as well as orienting new staff to the provider's policies and procedures governing staff and their work.
- Staff received individual supervision once a month. They could attend reflective practice group supervision once a month. They received an annual appraisal.
- A hundred percent of non-medical staff had received an appraisal in the 12 months prior to our inspection apart from those staff that had been in post for less than a year.
- Equality and diversity training accounted for a module within the care certificate. Equality and diversity training compliance for staff not engaged with the care certificate was at a low level of only 40%.
- Staff received specialist training in working with patients with a primary diagnosis of personality disorder.
- Staff received security training to ensure they understood the importance of environmental and relational security in minimising potential risks.
- Poor staff performance was managed as per the provider's human resources policies.

Multi-disciplinary and inter-agency team work

- Patients were seen by the multidisciplinary team (MDT) once every two weeks. The MDT and the patient would review the patient's current situation regarding their mental state, risks and the patient's progress towards identified goals. They reviewed the patient's medicines prescriptions and adjusted these if necessary. They reviewed the patient's Section 17 leave entitlement and adjusted this if required.
- Nurses handovers were comprehensive and included details of the patients legal detention status, the patient's mental state, medicine compliance and any side effects, their physical health status, their risk status, their observation level and their Section 17 leave entitlement. The nurse receiving the handover documented the handed over information.
- There were effective working relationships with teams outside of the organisation such as local authority safeguarding teams and GPs.
- Staff had good relationships with local voluntary organisations that supported patients to secure employment in the local community. This could be challenging due to some patients offending history.

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

- Staff compliance with mental health act (MHA) training was 100%.
- Staff were trained in and have a good understanding of the MHA, the Code of Practice and the guiding principles. The mental health act administrator was aware of the Cambian policies currently being updated and had taken steps to ensure training reflected the changes to the code of practice. An information leaflet had been designed and used for the hospital to help update the staff.
- Consent to treatment and capacity requirements were mostly adhered to and copies of consent to treatment forms were attached to medicine charts where applicable. This meant staff were aware of the legal requirements relating to medicine administration for each patient.
- One chart incorrectly had a T2 (Section 58 consent to treatment document) attached; it should have been a T3. The patient was unable to give consent
- Patients had their rights under the MHA explained to them on admission and routinely thereafter.
- Administrative support and legal advice on implementation of the MHA and its code of practice was available from the MHA administrator. Staff knew how to contact the MHA administrator if they needed advice or guidance.

Requires improvement

Forensic inpatient/secure wards

- Detention paperwork was filled in correctly, up to date and stored appropriately.
- Staff undertook regular audits to ensure the MHA was being applied correctly.
- Patients had access to independent mental health advocacy (IMHA) services and staff were clear on how to access and support engagement with the IMHA to capture the wider issues of referrals, capacity issues, access to wards and care records.
- Mental Health Act (MHA) policies did not reflect the changes to the Code of Practice in April 2015. Cambian Healthcare Limited had an action plan to complete this task by 30 April 2016. However, this was not appropriately timely given the change in policy took place in April 2015 12 months prior to inspection.

Good practice in applying the Mental Capacity Act

- Staff were 100% compliant with mental capacity act (MCA) training.
- Staff were trained in and had a good understanding of MCA 2005, in particular the five statutory principles. They were able to accurately describe capacity as being decision- specific and fluctuating and could give appropriate examples.
- All patients had been appropriately assessed for capacity.
- The provider had a policy on MCA to guide staff.
- Staff understood and where appropriate worked within the MCA definition of restraint. Section 6(4) of the Mental Capacity Act 2005 states that restraint is when someone uses force (or threatens to) to make someone do something they are resisting, and when someone's freedom of movement is restricted, whether or not they are resisting. Restraint can be appropriate when used from time to time to prevent serious harm to a person who lacks capacity if it is a proportionate response to the likelihood and seriousness of the harm, and if all other less restrictive means of achieving this have been tried.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- Care records demonstrated staffs' understanding of the individual needs of the patients.
- We saw staff treating patients respectfully. They were discreet and observant of patient confidentiality. Staff provided appropriate practical and emotional support.
- Patients we spoke with told us staff were kind and treated them with respect and upheld their dignity. However, one patient told us he did not like staff wearing their Cambian uniform when escorting him on Section 17 leave as this readily identified them as mental health service staff.

The involvement of people in the care they receive

- Patients were oriented to the ward when they were admitted. Staff provided them with information regarding when meetings such as community meetings and multidisciplinary team meetings would take place, and what rules were in place to support community living with their fellow patients.
- Patients' care records demonstrated patients being involved in their care planning and risk assessments. Patients told us they were involved in their care plans. Patients were offered copies of their care plans and if they declined the offer this was clearly documented in their care records.
- Patients could access advocacy services. They could self-refer or request staff to facilitate. The advocate visited the hospital every week on a Wednesday and a Thursday to attend ward community meetings so patients could see him then if they wished.
- Patients could give feedback about the service in weekly community meetings and in patient surveys.
- Patients were involved in interview processes for new staff.
- Patients had advance statements in place detailing their preferences for care and treatment.
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Requires improvement

Forensic inpatient/secure wards

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- In the six months between September 2015 and February 2016 the average bed occupancy was 91%.
- There were no delayed discharges from the service in the same time period.
- Average referral to treatment times at the Ansel Clinic was 108 days. This was mainly due to outside circumstances such as funding.
- Beds were available at the hospital for people living in the local area.
- Patients were not moved between wards during an admission episode unless this was justified on clinical grounds and was in the interests of the patient.
- When patients were moved or discharged this happened at an appropriate time of day. This is important because patients should ideally be moved at a time of day when a full range of professionals would be available to provide care, treatment and support to the patient.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had access to a full range of rooms to support treatment and care. There was a computer room, a kitchen for cooking and therapy rooms.
- Patients had access to a quiet room when they wanted to get away from the day to day activity on the wards.
- Patients were able to make phone calls in private. Patients were individually risk assessed for access to their own mobile phones.
- Patients had access to a secure outdoor space.
- Patients told us the food was of a good quality. During our inspection we saw meals which looked tasty and nutritious.
- Patients could make drinks and snacks 24 hours a day if they chose to do so.
- Patients were able to personalise their bedrooms to reflect their taste and preference.
- Patients were able to securely store their possessions in their bedrooms.
- Patients had access to activities including in the evenings and at weekends. Some patients were attending college and were studying for formal qualifications; one patient was learning to play the violin.

Meeting the needs of all people who use the service

- The hospital was fully accessible for people with disabilities.
- Information leaflets were available in a variety of languages in case patients did not have English as their first language.
- Accessible information was available regarding treatments provided, local services and voluntary organisations, patients' rights, how to complain and advocacy services.
- Staff were able to access interpreters or signers if patients needed their support for communication with staff or other professionals such as solicitors.
- Spiritual support could be provided by local spiritual leaders. Staff knew how to contact local spiritual leaders.
- Most patients told us their dietary requirements were adequately met.

Listening to and learning from concerns and complaints

- Since July 2015, the hospital reported 38 complaints. Seven of these complaints were 'upheld'. None of the complaints were referred to the Independent Sector Complaints Adjudication Service (ISCAS). None of the complaints were referred to the Ombudsman.
- Patients knew how to complain and received feedback. The advocate attended the hospital and visited both wards weekly so any patients uncertain of how to complain were supported to do so.
- Staff knew how to deal with complaints appropriately. The provider had a policy to support staff in dealing with complaints.
- Staff received feedback on the outcome of investigations of complaints in handovers, the ward communication book, in supervision and in staff meetings. Patients told us changes had been made for them regarding their care in response to complaints they had made.

Requires improvement

Forensic inpatient/secure wards

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- The Ansel Clinic Nottingham was purchased by Cambian in 2015. They then took full control of the management of the clinic in early 2016. As a consequence the Cambian vision and values were not yet fully embedded at the time of our inspection.
- Managers had set objectives to reflect Cambian's values and objectives. Cambian believes 'everyone has a personal best'.
- Staff knew who the most senior managers were and told us some of these managers had visited the wards. The registered manager was at the hospital every day from Monday to Friday. The operations director who was the nominated individual for the service was a frequent visitor to the service as he was seeking to support the implementation of the Cambian model of care.

Good governance

- Staff had received all required mandatory training except for equality and diversity.
- Staff had been appraised and had regular access to supervision.
- Rotas demonstrated adequate staffing levels which met set staffing levels. Staff maximised shift-time on direct care activities rather than administrative tasks. This was demonstrated in care records and we saw this during our inspection.
- Staff actively participated in a range of clinical audits.
- Staff recorded and reported incidents appropriately.
- Staff learned from complaints and patient feedback. However, there was little evidence of any local learning from risk incidents involving individual patients risk behaviours.
- Managers participated in regular local and regional governance meetings to analyse data relating to incidents, complaints, staffing and audit outcomes.
- Staff followed procedures for safeguarding, mental capacity act and mental health act.
- Managers used key performance indicators to ensure they were meeting requirements for appraisal, supervision and staff training.
- The registered manager had sufficient authority and was adequately supported by administrative staff.
- Staff could submit items to the provider's risk register. At the time of our inspection there were three items on the risk register from 2015.. All identified risks were being addressed through appropriate action plans.

Leadership, morale and staff engagement

- In the time period April 2015 to March 2016 staff sickness rates were consistently below the national average of 4.4%. The highest sickness absence for registered nurses was 2.2% and occurred in the period October 2015 and December 2015. The highest sickness absence for support workers was 3.4% and occurred in the period January 2016 to March 2016.
- There were no active bullying and harassment cases for the 12 months prior to our inspection.
- Staff told us they knew how to use the whistle-blowing process.
- Staff told us they felt able to raise concerns without fear of victimisation.
- Some staff told us their morale was good. Some staff told us they were unhappy about many of the changes Cambian had made in the months prior to our inspection. Their complaints were in relation to the non-payment of sickness absence, the wearing of uniforms and lanyards. Staff told us the lanyards posed a strangulation risk. However, the lanyards were specially designed to come apart when pulled with any force, so the strangulation risk was adequately mitigated.
- Staff had opportunities for leadership development by being allocated specific roles such as security nurse or nurse in charge. Cambian were supporting a support worker to work towards a nursing registration.
- All staff told they valued their colleagues and were confident they are an effective team who worked well together. Staff told us they felt well supported at a team level and by managers of the service.
- Staff told us they were open and honest with patients and apologised when things went wrong.
- Staff had the opportunity to provide feedback on services in staff meetings and in staff surveys.

Commitment to quality improvement and innovation

- The provider was not involved in any national quality improvement programmes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all equipment is adequately maintained and subject to appropriate checks.
- The provider must ensure that all Mental Health Act(MHA) policies are reviewed and updated in line with the revised MHA Code of Practice

Action the provider SHOULD take to improve

- The provider should ensure that all staff are aware of the correct procedures to follow for seclusion.
- The provider should ensure that patient privacy and dignity is protected by escorting staff on section 17 leave, by staff avoid being readily identifiable as mental health service staff.
- The provider should ensure that all medicine charts have the correct consent to treatment authorisation based on capacity to consent attached to all medicine charts.

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 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: Clinic equipment on Acorn ward had not been consistently checked Clinic room equipment had not been calibrated. A kettle and a television had no stickers to demonstrate safety checks had been undertaken. This was a breach of Regulation 15(1)(e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Cambian Mental Health Act policies had not been updated to reflect the Mental Health Act 1983 current code of practice (2015) This was a breach of Regulation 17(2)(a)