Battersea Bridge House Limited

Battersea Bridge House

Inspection report

1 Randal Close
Battersea
London
SW11 3TG
Tel: 02079247991
www.inmind.co.uk

Date of inspection visit: 26 and 31 October 2022
Date of publication: 16/01/2023

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as requires improvement because:

- We rated the service as requires improvement for safe and well-led. This was a follow-up inspection to the comprehensive inspection in November 2021. Whilst the service had made improvements in some areas, there was still more work to do to ensure they delivered consistent high quality care.
- The service did not have a local procedure in place to safely monitor drugs liable for misuse (DLM), which was against the provider's medicines management policy. There were discrepancies (of 3 tablets) between the number of DLM recorded as stock and the actual number of physical medicines on all three wards.
- The service did not always have robust governance systems to ensure the quality and safety of the service. There had been a recent lapse in some quality assurance processes and some actions from the previous inspection remained outstanding or had taken a long time to action. We found a number of issues that were still outstanding from the issues identified in the last inspection in November 2021. The service was unable to provide assurance that the blood glucose testing kits were suitable for use, not all staff were trained and assessed as competent to complete medicines tasks, and risk assessments were not always up to date and did not outline how staff would mitigate identified risks.
- The staff turnover rate was high at 33%, which impacted consistency of care delivered to patients. This service had risk-rated staff turnover as red on their site improvement plan, but it lacked robust actions to encourage staff retention.
- The service had not been able to consistently offer a range of nationally recommended psychological therapies due to difficulties in recruiting a forensic psychologist since our last inspection. At the time of the inspection, a forensic psychologist had recently started in post.
- Records did not contain all necessary information. Electronic records were comprehensive and updated following changes in patients' risk or need. However, staff did not always update paper records to reflect these changes.
- The service had been slow to ensure all staff were compliant with fire evacuation training. The service had identified the training need in 2021, but compliance remained low at 51%.
- There were delays in discharges of care. Some patients told us they found these delays frustrating. As a result, some patients were ready to move on but unable to. The hospital had a full bed occupancy and were unable to admit any new patients.
- There were a number of new appointments to the multidisciplinary team at the time of the inspection, therefore, the staff team still needed support to develop an effective working culture.

However:

- Our ratings for safe, effective and caring improved since our last inspection in November 2021. The service had made a number of improvements . For example, ligature risk assessments were up-to-date, personal emergency evacuation plans were in place, night-time staffing had increased, and out of hours medical cover had improved. A quality improvement manager had been employed to support the team to make improvements in quality and safety.
- Most patients told us they felt safe. The ward environments were safe and clean.
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients.

Summary of findings

- Each patient had their own bedroom with an en-suite bathroom and could keep their belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Page

Background to Battersea Bridge House 6

Information about Battersea Bridge House 7

Our findings from this inspection

Overview of ratings 9

Our findings by main service 10

Summary of this inspection

Background to Battersea Bridge House

We undertook this unannounced comprehensive inspection of Battersea Bridge House to see if they had made improvements following the concerns found in our inspection in November 2021.

Battersea Bridge House is a low secure independent hospital in South West London. It provides care and treatment to men aged 18 years and over with severe mental illness and additional complex behaviour. Battersea Bridge House is part of the Inmind Healthcare Group, an independent provider of mental health and social care services.

The service has 22 beds and it provides services across three wards:

• Browning ward has 10 beds

• Blake ward has six beds

• Hardy ward has six beds

At the time of our inspection all 22 beds were occupied. All patients receiving care and treatment 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.

The hospital director is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service.

Battersea Bridge House registered with the CQC in December 2010. There have been eight inspections. We last inspected Battersea Bridge House in November 2021 when we rated the service as 'requires improvement' overall, with a rating of inadequate for safe, requires improvement for effective, caring and well-led, and good for responsive.

What people who use the service say

We spoke with nine patients across the three wards on the first day of the inspection. Patients were mostly positive about their experience on the wards. Two patients described the ward environment as calm and one patient described it being like a 'family'. Most patients said the staff were caring, although one patient said agency staff were rude and another patent said staff can be disrespectful.

Summary of this inspection

All patents said they had authorised leave from the hospital. Some patients said there were a variety of activities that they enjoyed, whilst some patients said there were a lack of activities, particularly on the weekends. Patients said that sometimes there were not enough staff to facilitate activities. All patients had one to one meetings with their nurses, and the multidisciplinary team.

Most patients said they felt safe on the ward, whilst two patients said they did not. Two patients said that they were frustrated with the delays in their discharge from the hospital.

How we carried out this inspection

The team that inspected this service consisted of two CQC inspectors, two CQC inspection managers, an expert by experience and a specialist advisor who had experience working within low secure environments.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

During the inspection visit, the inspection team:

• visited the service, observing the environment and how staff were caring for patients

• spoke with 9 patients who were using the service

• spoke with 5 carers of those using the service

• spoke with 17 members of staff including, the hospital director, consultant psychiatrist, team leads, nurses, support workers, forensic psychologist, physical health nurse, the support service manager, an occupational therapy assistant, a social worker.

• reviewed 4 patient care and treatment records.

• checked how medication was managed and stored, including reviewing 19 prescription charts

• reviewed three staff records

• reviewed information and documents relating to the operation and management of the service.

Summary of this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take to improve:

- The service must ensure that there is a local procedure in place to monitor drugs liable for misuse, in line with the provider's medicines management and administration policy. The service must ensure all staff are trained and assessed as competent to complete medicines tasks. **Regulation 12**
- The service must ensure that collaborative and specialist forensic risk assessments (HCR-20) are regularly reviewed and updated. **Regulation 12**
- The service must ensure systems are in place to ensure the efficacy and safety of blood glucose monitoring kits. **Regulation 12**
- The service should ensure that all staff are up to date with fire evacuation training to ensure good fire safety. **Regulation 12**
- The service must ensure that appropriate systems and processes are in place to ensure the safety and quality of the service, and that identified actions and recommendations to improve the service are responded to in a timely manner. **Regulation 17**

Action the service SHOULD take to improve:

- The service should consider that, where appropriate, patients are offered a range of nationally recommended psychological therapies.
- The service should ensure that paper care records are up to date and reflect a change in need or risk.
- The service should ensure staff plan for patients' discharge, including good liaison with care managers/coordinators and ensure discharge is never delayed for other than clinical reasons.
- The service should ensure actions are in place to support staff retention in order to ensure consistency of care is delivered to patients.
- The provider should consider ways to support the development and working relationships of the largely new multidisciplinary team.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Forensic inpatient or secure wards

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

Are Forensic inpatient or secure wards safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff now completed assessments of risks on wards. At the last inspection in November 2021, staff did not regularly update risk assessments of all ward areas. At this inspection, this was no longer the case. Staff carried out regular risk assessments of the care environments. The risk assessment was due for review in January 2023 and included a range of identified risks, including scalding and burning from hot surfaces and hot water and COVID-19. The assessment outlined ways in which the risks were mitigated.

At the last inspection in November 2021, the ligature risk assessment was out of date. At this inspection this was no longer the case. The ligature risk assessment had been reviewed and responsibilities clarified. Actions required to minimise or mitigate the risks were stated and photographs of the risks included. Blind spots had been reviewed and mirrors installed where appropriate.

Staff we spoke with were aware of ligature points on the wards, and they referred to a document detailing ligature point photographs on the wards.

The service was for male patients only. All patient bedrooms had en-suite facilities.

Staff and patients had easy access to alarms and nurse call systems. All patient bedrooms had wall alarms. Staff carried alarms while on the wards.

At the last inspection in November 2021, not all patients on the wards had personal emergency evacuation plans readily available in case of a fire emergency. At this inspection, this was no longer the case. All patients had up-to-date personal emergency evacuation plans, which were easily accessible.

Requires Improvement

Forensic inpatient or secure wards

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Domestic staff cleaned communal areas daily. Cleaning records were available for these areas. Patients were responsible for keeping their own bedrooms clean. Staff offered cleaning support to patients where needed.

The foot pedal operated bin in the clinic room on Hardy Ward did not open as the foot pedal was broken. The bin needed to be replaced.

There was a tall locker in the activity room on Browning Ward that was locked, and the team lead did not know what the locker was for or where the keys were. The locker was wobbly and posed as a falling hazard.

Staff followed infection control policy, including handwashing.

At the last inspection in November 2021, the service did not always comply with corporate policy in relation to infection control as some staff did not wear protective face coverings. At this inspection, this was no longer an issue. Staff wore face masks in line with local policies.

Fire drills had been carried out in September 2021 and April 2022. Comments on the fire drill records identified actions and improvements needed. Staff carried out weekly and monthly fire safety checks. The fire alarm system was regularly inspected and serviced.

Seclusion room

The seclusion room was located on the ground floor of the hospital. Patients from other wards had to be escorted down a set of stairs and this was sometimes necessary to do under restraint. The ward was aware of this complication and had training available for staff in how to safely support patients.

At the last inspection in November 2021, there was no clock in the seclusion room. At this inspection, there was a clock, which displayed the date and time. The seclusion room allowed clear observation and two-way communication. The seclusion room had toilet facilities.

The service had improved the safety of the seclusion room, but some renovations were still needed. At the last inspection in November 2021, there were frames around the window and door, which were potential ligature anchor points, and the metal hatch in the bathroom area was coming loose and was a potential self-harm risk. These concerns had been addressed. However, we found other concerns with the environment during this inspection. Some of the mastic around the panels in the seclusion room bathroom were starting wear away creating sharp corners on these panels, and some of the screws around the window panel were no longer flush, creating a self-harm risk. These issues were raised with staff at the time of the inspection who raised it with the maintenance team. Managers acknowledged that the seclusion room was in need of a refurbishment, and it was included on the service's improvement plan. Following the inspection, the board stated that the hospital would be moving away from the forensic low secure contract in the second quarter of 2023, and towards a clinical model of rehabilitation. As part of this change, the hospital will go through significant refurbishment and the seclusion room will be configured appropriately for the new clinical model.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Requires Improvement

Forensic inpatient or secure wards

At the last inspection in November 2021, we found expired emergency medicines available for use. At the inspection, this was no longer the case.

Staff checked, maintained, and cleaned equipment. At the last inspection in November 2021, there was no cleaning records to confirm the cleaning of this equipment. At this inspection, staff maintained cleaning records of when the clinical room was cleaned.

The service did not have a robust system in place to demonstrate that blood glucose kits had been checked. At the last inspection in November 2021, the provider was unable to provide assurance that the kits were suitable for use. This meant that there was a small risk that the blood glucose readings for patients may not have been accurate. At this inspection, this was still an issue. The registered manager was unable to provide past records of calibration of the glucose testing kits on Hardy and Browning Ward. Therefore, we were unable to certify when these had previously been completed. They had new sheets in place that stated they had been checked on the day of our inspection. On Blake Ward, records demonstrated that the machine had not been calibrated since 20 September 2022.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had improved its nurse staffing. At the last inspection in November 2021, the service did not always have enough staff. There were occasions when a ward was staffed by a single support worker.. At this inspection, improvements had been made. With the use of bank and agency staff, the service had enough nursing and support staff to keep patients safe and provide the right treatment and care. The nighttime staffing for registered nurses had increased from two to three, which meant there was always a registered nurse allocated to each ward.

The staff establishment was 14 registered nurses and 20 non-registered nurses. . At the time of the inspection, there were vacancies for 4.5 registered nurses and 6 non-registered nurses. The service was actively recruiting into vacant posts. This included undertaking recruitment overseas.

Staff vacancies were covered by bank and agency staff who were mainly familiar to the service. For the month of September 2022, 49 shifts were carried out by agency registered nurses, and 114 agency support workers. In the last six months, 4 shifts were not filled by agency or bank staff where there were sickness, absence or vacancies.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers undertook checks on prospective employees before they started work in the service. We reviewed the files of three staff. The records showed that checks had been carried out with the disclosure and barring service prior to a person's employment, proof of identity was obtained along with satisfactory evidence of conduct in previous employment and a full employment history including explanations of any gaps.

In the last 12 months, the staff sickness rate was 12% for registered nurses, and 6% for support workers.

In the last 12 months, the staff turnover rate was high at 33%. The site improvement plan highlighted actions in relation to the high staff turnover in the service, which they had risk-rated red. Recruitment was ongoing and a staff survey was to be completed to help in the design of a staff retention plan. The operations manager, who was responsible for recruitment, said there were no particular incentives to encourage staff retention, although this was being considered.

Requires Improvement

Forensic inpatient or secure wards

Managers accurately calculated and reviewed the number and grade of nurses and support workers for each shift.

The hospital manager adjusted staffing levels according to the needs of the patients. Additional staff were booked if patients required a higher level of observation or there were pre-booked activities that affected staffing, such as trips and community activities.

Patients had regular one-to-one sessions with their named nurse. All patients reported having one-to-one sessions. Patients rarely had their escorted leave cancelled. They did, however, say that sometimes there were not enough staff to facilitate activities.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. Staff held a handover meeting at the start of each shift. Staff used the handover to discuss any incidents that had occurred and update patient risk information. This ensured that information was passed onto staff coming onto shift and that staff were aware of the individual risk rating of each patient.

Medical staff

The service had enough medical cover to keep patients safe from avoidable harm.

At the last inspection in November 2021, the service did not have enough daytime and night-time medical cover. The hospital had one consultant psychiatrist as its only provision of medical cover. At this inspection, this was no longer the case. Out of hours medical cover was now shared between the consultant, a consultant psychiatrist from another of the provider's services and a speciality doctor shared between the two services.

Mandatory training

Staff had completed and mostly kept up to date with mandatory training to ensure they had the appropriate knowledge and skills to carry out their roles safely. At the last inspection in November 2021, mandatory training compliance fell below the service's 80% target in eleven courses. For example, basic life support, mental health act awareness and medication management. At this inspection, improvements had been made. Staff we spoke with said they had completed and were up to date with their mandatory training. Overall, staff in this service had undertaken 89% of the mandatory training, which exceeded the hospitals overall training target of 80%. The service provided 22 training courses that were mandatory for all or some members of staff. These included basic life support, equality and diversity and health and safety, which were all at 100% compliance

Compliance with five mandatory courses were below 80%. These included fire evacuation chair training at 51% compliance, medicines awareness at 75% compliance, mental health act awareness at 55% (this training was interrupted as it coincided with the first day of our inspection), physical intervention breakaway at 63% compliance, physical intervention holding at 78%, and national early warning score at 78% compliance. The provider's annual fire risk assessment carried out in 2021 identified the need for staff to complete training in the use of the fire evacuation chair, but only 51% of staff had completed the training. This meant there was a risk that only half of the staff were trained or had the correct knowledge to safely evacuate patients using the chair if required in the event of a fire. The provider recognised this issue and had planned fire evacuation chair training for November and December 2022.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Requires Improvement

Forensic inpatient or secure wards

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves, but they did not always ensure that assessments were updated. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We reviewed four patient records. Risk assessments were not always up to date and did not outline how staff would mitigate identified risks (which was an issue picked up in the November 2021 inspection). For two patients (out of four records reviewed), their collaborative and HCR-20 risk assessments were not updated to include significant physical health risks. For example, for one patient their physical health deteriorated, and they were admitted to general hospital and treated for serious conditions. The individual was discharged and returned to the service, but their risk assessment was not updated with this information. This was raised with the registered manager who stated this should have picked this up in their care record quality audit.

Three out of four patients did not have a complete or up to date HCR-20 risk assessment. The newly appointed forensic psychologist recognised this issue and had planned fortnightly risk review meetings to ensure HCR-20 risk assessments are reviewed and updated at least every 6 months. The forensic psychologist planned to introduce the Short-Term Assessment of Risk and Treatability (START) assessment tool.

Management of patient risk

Staff knew about any risks to each patient. Patient risk was discussed in handover meetings, which was attended by all staff on shift.

Staff identified and responded to any changes in risks to, or posed by, patients. For example, additional observations were carried out or additional staff were rostered on shift when required. At the time of our inspection, one patient was on one-to-one staff observations due to physical health risks.

Staff followed procedures to minimise risks where they could not easily observe patients. Patients were checked in line with the observation levels set by the clinical team. These ranged from one-to-one continuous observation, to intermittent and general observations.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff and patients were aware of these procedures.

At the last inspection in November 2021, patients did not have individual risk assessments in place for use of technology, such as mobile phones, tablets and computers, in line with provider policy. At this inspection, this was no longer an issue, and all patients had a risk assessment in place for the safe use of technology.

Use of restrictive interventions

Levels of restrictive interventions were low. There had been five incidents of restraint in the last 12 months. Of these incidents of restraint, none were in the prone position. Staff participated in the provider's restrictive interventions reduction programme.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation. There had been no incidents of intramuscular rapid tranquilisation in the last 12 months.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. In the last 12 months, there had been two episodes of seclusion. Both patients had been from Blake Ward. Records for episodes of seclusion were clear, showing reasons for seclusion, and dates and times of commencement and termination. Medical and multidisciplinary team reviews had taken place quickly. Nursing two-hourly reviews had all taken place and monitoring observations every 15 minutes were recorded. For one of the records, it was not clear why seclusion had been terminated for a patient who attended A&E for medical attention. This was raised with managers who provided clarification.

There was a seclusion care plan that detailed risks, what needed to happen for seclusion to end, food and fluid plans, patient views, removed items and whether families were to be informed.

There had been no incidents of long-term segregation in the last 12 months.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

At the last inspection in November 2021, not all staff understood how to safeguard patients from abuse. Staff had training on how to recognise and report abuse, but they did not always know how to apply it. At this inspection, this was no longer the case. Staff we spoke to were aware of the safeguarding processes and knew who the safeguarding leads were. Staff were kept up to date with their safeguarding training, and at the time of inspection, training compliance for safeguarding children and adults was 98%.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information, whether paper-based or electronic, but staff did not always update paper records with all necessary information. Paper records were not consistently updated after a change in need or risk –.

Requires Improvement

Forensic inpatient or secure wards

At the last inspection in November 2021, clinical information was not always accessible, and the service did not maintain high quality clinical records. There was a mix of paper and electronic records. At this inspection, there was still an issue with the quality of clinical records. The provider still used a mix of paper and electronic records. We found that electronic records were mostly comprehensive and demonstrated good service user focused discussion. However, paper records were not consistently updated after a change in need or risk. For example, care plans did not reflect changes to physical health concerns or learning difficulties where they were relevant. Care records did not always document patients' discharge plans. This meant there was a risk that staff may not be aware of important information regarding a patients' care. We raised this with the registered manager during the inspection, who reported that there had been a recent lapse in the last month of the daily audit of paper care records. The provider had plans in place and a contract signed, to move over to using only an electronic care record system in the first quarter of 2023.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. However, the service did not have robust systems in place to monitor drugs liable for misuse, and not all nursing staff were up to date with their medicine competency checks.

At the last inspection in November 2021, staff did not always follow systems and processes to prescribe and administer medicines safely. For example, escalating fridge temperatures that fell outside of parameters and monitoring medicines expiration dates. At this inspection, improvement had been made. Effective systems were in place to ensure fridge temperatures were within range and medicines were within expiry dates. However, we found other concerns with the management of drugs liable for misuse (DLM). We found discrepancies between the number of medicines recorded as stock and the actual number of physical medicines on all three wards.

The provider's medicines management and administration policy, dated August 2021, stated that local procedures must include how drugs liable for misuse are monitored on site. Managers told us there was no written local procedures for the monitoring of DLM at the service. This meant that the service was not adhering to the provider's policy.

This was raised with managers during the inspection, who stated that this was most likely due to inaccurate recording rather than medicines being diverted / going missing. However, since the service did not have a local procedure in place to monitor DLM, they were not sighted on this issue. Managers immediately completed an internal audit of DLM. They found a recording error for some of the tablets, but three were still unaccounted for. Further to this, the provider made immediate changes to the way DLM were managed. They changed procedures for recording DLM stock, which would also be checked during handovers to improve monitoring and ensure an audit trail. Access to stock DLM would be managed by two qualified nurses on shift. All patient medicine charts will have a reminder for staff to complete the DLM register if they dispense DLM. The pharmacist said they would support the team with these changes.

At the last inspection in November 2021, not all staff were up to date with their medicines training. At this inspection, this was still an issue. The registered manager confirmed that the service had not ensure that all nursing staff had completed their competencies to manage medicines safely Although, they confirmed that there were plans in place for the pharmacist to support nursing staff with medicine competency checks the week commencing 14 November 2022.

Requires Improvement

Forensic inpatient or secure wards

The service employed an external pharmacist to provide on-site weekly visits. They undertook monthly medicines audits. Results of the audits were sent to the service and any shortfalls were discussed at the integrated governance meeting. Any medicine incidents, including errors, were reviewed by the responsible clinician and hospital manager. Staff learned from safety alerts and incidents to improve practice.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. For example, Clozapine and Lithium.

Track record on safety

The service had a good track record on safety.

There had been non serious incidents in the last 12 months.

There had been a death in 2020, which showed there had been a delay in starting cardio-pulmonary resuscitation (CPR). The South London Partnership, who commissioned the service, were meeting with the registered manager monthly to review an action plan in response to this, which included CPR simulations. We saw evidence that staff attended monthly clinical emergency simulations to support them a variety of emergency's that may occur on the wards. Information on emergency scenarios were also included in staff induction packs.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with provider policy.

In the last 12 months, the service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Requires Improvement

Forensic inpatient or secure wards

Staff received feedback from investigation of incidents, both internal and external to the service. The registered manager attended monthly governance meeting with managers at two other InMind services, where incidents and lessons learnt were discussed. Lessons learned from incidents was a standing agenda item at monthly staff team meetings. We saw an example of an emphasis on improved patient searches.

Managers shared learning with their staff about never events that happened elsewhere. For example, the registered manager had produced learnings from a very serious case of abuse that occurred at a mental health hospital elsewhere in the country. They looked at restrictive practices, culture and systems failure and how they could work towards improving their own service.

Are Forensic inpatient or secure wards effective?

Good

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion; however, paper care plans were not always updated following change in need or risk. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. The assessment included details of the patient's presentation, mood and insight into their mental health condition and forensic history.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Since our last inspection in November 2021, the service had employed a full-time physical health nurse to improve oversight of the physical health of patients and took the lead with ensuring regular physical health checks.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff did not, however, always update these care plans following a change in risk or need. For example, not all patients' discharge planning was consistency updated. Of the four patient records we reviewed, one did not clearly record the support needs of the individual regarding discharge planning. This individual's records stated a need to live independently however there was no mention for supporting this individual to in feeling comfortable to accept accommodation. The individual's electronic ward round notes highlighted this as a primary need and barrier for this person, but this was not updated in their care plan.

The service had introduced the recovery star tool to improve care planning, encourage patient involvement in care and to make care more person-centred.

Care plans were personalised, holistic and recovery orientated. This was an improvement from the inspection in November 2021. We found a comprehensive positive support behaviour plan for a patient with learning difficulties. It detailed ways to support the patient if they presented with challenging behaviour and mitigations for identified risks.

Requires Improvement

Forensic inpatient or secure wards

Best practice in treatment and care

Staff provided care and treatment suitable for the patients in the service. However, difficulties with recruiting a permanent psychologist impacted upon the provision of best practice treatment for some patients. Staff ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Whilst staff provided a range of care and treatment suitable for the patients in the service, the lack of permanent psychologist input over the last year made it difficult to deliver the provision of best practice treatment for some patients. At the last inspection in November 2021, the service did not have a psychologist in post. Patients were therefore unable to access psychological therapy and specialist forensic risk assessments were not being reviewed or updated. At this inspection, improvements still needed to be made. The service had not been able to consistently offer a range of nationally recommended psychological therapies due to difficulties in recruiting a forensic psychologist. A locum psychologist had been employed covering 3 days a week from March 2022 until October 2022. A forensic psychologist and assistant psychologist had recently started work in the service. They were taking time to assess and understand the needs of patients before providing appropriate therapies and support. The assistant psychologist had been in post for 3 weeks and said they were focused on building trust with patients. The forensic psychologist had been in post for six weeks and was focused on setting up the psychology department. They had planned a bi-weekly risk review to update HCR-20 risk assessments and introduce Short-Term Assessment of Risk and Treatability (START) risk assessments. The psychologist and assistant psychologist had recently conducted a needs analysis and concluded twelve patients were ready for psychological intervention.

Staff made sure patients had access to physical health care, including specialists as required. The service had improved liaison with a local GP and discussions about patients took place every 2 weeks or more frequently if needed. The service had employed a full-time physical health nurse to improve oversight of the physical health of patients. They took a lead on taking bloods, performing electrocardiograms, and booking optician and dental appointments for patients, and they accompanied patients to external appointments related to their physical health. They also provided training to colleagues and checked staff competencies to use new equipment, such as manual blood pressure monitors. When the physical health nurse identified the need for new medical devices/equipment they raised this with the registered manager who obtained them.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Information was displayed on the wards regarding help to stop smoking and healthy eating.

Staff measured outcomes for patients using length of stay data, discharge destination, service user surveys, the model of human occupation screening tool (MOHOST) and health of the nation outcome scales.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. An audit calendar had been put in place to help ensure audits took place as planned. There were named staff responsible for each audit. More audits of medicines had been implemented with additional support from an external provider.

Managers used results from audits to make improvements. For example, staff completed a Section 17 Leave audit. This showed inconsistency when updating patients' Section 17 Leave paperwork. Staff discussed this and as a result the recording and communicating of patients' Section 17 Leave was improved which made it easier for patient to take their leave.

They had started running a games group and were doing some individual work with a patient in relation to improving their sleep. Another patient was being supported to work in a charity shop.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards, although there had been gaps in psychology provision over the last year. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included doctors, registered nurses, a social worker and an occupational therapist. A forensic psychologist had very recently joined the team 3 days per week. There were plans for them to become full-time in the new year. An assistant psychologist was also new to the team.

The service employed an external pharmacist to provide medicines management support to the team. The also pharmacist delivered three medicines training seminars every year.

The service had employed a full-time physical health nurse to improve the care and support provided to patients in relation to their physical health.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Although, not all nursing staff had completed their medicine competency checks. Plans were in place for this to be addressed during November 2022.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular supervision, in line with their staff supervision policy. In the last six months, 84% of staff received regular supervision.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed staff team meeting minutes from the past five months, which showed good attendance from the MDT. Minutes were available for those who could not attend.

At the last inspection in November 2021, not all supervisors had up to date information related to their supervisees, for example, their current training records. At this inspection, this was no longer the case. Supervisors we spoke with followed a supervision tree format and were clear on who they supervised and kept records of their discussions. Supervisors met with their supervisees regularly, in line with provider policy.

Staff told us that there had been no group reflective practice to support them with their role. The forensic psychologist recognised this need and had arranged for their external supervisor to visit the service twice a month to provide group reflective practice.

Staff told us they had the opportunity to develop their skills and knowledge in order to progress their careers.

Managers ensured that staff received the necessary specialist training for their roles. However, the registered manager identified that staff would benefit with extra training on how to manage patients with personality disorders.

Requires Improvement

Forensic inpatient or secure wards

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. All members of the multidisciplinary team and other staff worked together to understand and meet the range and complexity of patients' needs. Patients were invited in to discuss their care and treatment.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. The service had daily handover meetings each morning which discussed staffing, incidents, referrals, admissions, planned discharges, diary appointments and any other relevant issues. These were attended by the hospital manager and the wider clinical team. Each shift held a handover where incidents, patient care and risk were discussed.

Ward teams had positive working relationships with external teams and organisations. There were effective working relationships with other health and social care professionals. Staff worked with the local safeguarding team and patients' care coordinators in their local areas to facilitate effective discharge planning and follow-up care.

The service was part of the South London Partnership. Through this they were linked with other similar services in the surrounding boroughs for learning and development. At the time of the inspection, the registered manager was meeting with the South London Partnership monthly to discuss how they were safely meeting the needs of patients at the hospital.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Fifty-five per cent of staff had training in the Mental Health Act. Staff who needed to complete this training were booked into sessions during the day of our first inspection. Staff demonstrated they had a good understanding of the Mental Health Act, and the Code of Practice and the guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy services available to them. This was on display in patient areas on the wards.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Records showed staff explained rights and documented it in line with the Mental Health Act Code of Practice.

Requires Improvement

Forensic inpatient or secure wards

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff told us they had received, and were consistently up to date, with training in the Mental Capacity Act and understood the five principles. 98% of staff had training in the Mental Capacity Act.

There was a policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access via the service's computer system.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Are Forensic inpatient or secure wards caring?

Good

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Requires Improvement

Forensic inpatient or secure wards

We observed kind and respectful interactions between staff and patients. For example, we observed staff and patients playing board games in the communal area, whereby interactions were caring and jovial, and the environment was calm. Patients appeared at ease with staff. Staff spoke compassionately about patients.

The psychology team and occupational therapist met with patients each day for a games group.

Staff gave patients practical help, emotional support and advice when they needed it, for example, we observed a staff member supporting a patient who had mobility difficulties in their bedroom.

Staff supported patients to understand and manage their own care treatment or condition. Most patients said they felt involved in their care and treatment planning, however, two patients said that they were frustrated with the delays in their discharge from the hospital.

Staff directed patients to other services and supported them to access those services if they needed help.

Most patients said staff treated them well and behaved kindly. For example, one patient described the ward like 'one big family'. One patient, however, said agency staff were rude and another patent said staff can be disrespectful.

Staff that we spoke with understood and respected the individual needs of each patient. The staff and management team spoke respectfully about the people they cared for. They also spoke about the complexity of patients' mental illness and co-morbidities.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. Staff maintained the confidentiality of information about the patients. Patient information could only be accessed by staff authorised to do so. Any patient discussions were held in offices and meeting rooms to ensure patient confidentiality.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

At the last inspection in November 2021, staff did not involve patients in their care planning and risk assessment. At this inspection, this was no longer the case. Staff involved patients and gave them access to their care planning and risk assessments. We reviewed four care records that demonstrated patients' input and views.

Staff made sure patients understood their care and treatment. The multidisciplinary team held meetings with patients each week where their care and treatment was discussed. Staff held regular individual sessions with patients. Staff also involved patients in their Care Programme Approach (CPA) meetings. We saw that no decisions were made about any aspect of care or treatment without the involvement of the patient.

Requires Improvement

Forensic inpatient or secure wards

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients participated in regular community meetings and where they had opportunities to input their suggestions, give feedback and raise any concerns. The minutes of these meetings indicated that the patients felt confident in raising any concerns about the hospital.

Staff made sure patients could access advocacy services. An advocate visited the ward once a week. The patients were supported by the advocate at ward rounds, CPA meetings, Mental Health Act Tribunals, to make complaints, raise safeguarding concerns and provided feedback to the advocate about their care and treatment.

Patient representatives were appointed on each ward. They were given the responsibility of allocating a weekly budget for patient activities. We saw an example of patients organising a hospital BBQ with the ward budget available. The quality improvement manager described how the provider wanted to focus more on co-production with patients and carers.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff explained how they maintained contact with families and carers during each patient's stay at the service.

We spoke with 5 family members or carers. Four carers said staff were respectful and polite, and responsive if the carer asked them for information. One carer told us staff were impatient and irritable. Most carers felt that they were kept informed of developments regarding the patients' care. However, one carer did not feel up to date with their relative's care. All carers were aware of how to raise concerns or make a complaint if they needed to.

The service had arrangements in place to enable relatives and friends to visit patients safely.

The service collected feedback from carers. The social worker ran a virtual carers forum online once a month. About 4 or 5 carers attended regularly.

Are Forensic inpatient or secure wards responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. However, there were sometimes difficulties in finding suitable housing for patients who were ready for discharge, which led to delays in transfer of care. As a result, the hospital had a full bed occupancy and were unable to admit any new patients.

Requires Improvement

Forensic inpatient or secure wards

Bed management

The service worked closely with the South London Partnership provider collaborative and other commissioning teams in respect of admissions to the service. There was a clear admissions criteria and process. Clinical staff assessed patients before they were accepted into the service. Pre-admission assessments were carried out to ensure that the level of risk presented by the patient could be managed. Fifteen beds were used by commissioners in south London and 7 beds commissioned from north London.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay was just over two years, 752 days.). The service was working with commissioners and care co-ordinators to find suitable placements for longer-stay patients. The consultant psychiatrist described difficulties in finding suitable housing or accommodation for patients who were ready for discharge. Sometimes there were disagreements between organisations about which team would support the patient when they left hospital, and this had led to delays in discharge. The last discharge from the service had been 9 months before the inspection. Delays in discharge were affecting several patients. Beds were full at the service which meant there would be no new admissions until a patient was discharged. The average bed occupancy over the last 6 months was 98.45%.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. For example, when someone was progressing towards discharge, they would be moved to the pre-discharge ward where there was more focus on enhancing activities of daily living such as cooking and managing their own medication.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of patients whose discharged was delayed and took action to reduce them. However, we found delays in discharges of care, with 8 patients awaiting discharge, and the last discharge from the service being 6 months before our inspection. There were a number of reasons for delays in discharges. For example, 2 patients had turned down placements, other patients were assessed as needing in reach work prior to discharge and sometimes there were disagreements between organisations about which team would support the patient when they left hospital. The social worker was working with external teams to support these delayed discharges. We were told community team staff were invited to virtual meetings to discuss patient care and treatment but did not always attend. The delays in discharges of care appeared to be affecting patients, with two patients telling us that they were frustrated with the delays in their discharge from the hospital.

Staff worked with care managers and coordinators to plan and support discharges of care. However, not all patients' discharge care planning paperwork was up to date. Of the four patient records we reviewed, one did not clearly record the support needs of the individual regarding discharge planning. This individual's records stated a need to live independently. This was highlighted as a primary need and barrier in the patient's electronic ward round notes, however, there was no mention of this in their discharge care plan.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Requires Improvement

Forensic inpatient or secure wards

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. All bedrooms were en-suite with a toilet and handbasin.

Patients had a secure place to store personal possessions. There were lockers in patients' bedrooms.

Staff and patients had access to the full range of rooms and equipment to support treatment and care, for example, clinic rooms, lounges and space for activities. However, the ward areas were small. There was not always a private space to carry out interventions. For example, staff were carrying out lateral flow testing in the activities room on Browning Ward.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private areas such as their bedroom. They had access to the ward phone or used their own mobile phones.

The service had an outside space that patients could access. The garden was locked and patients were supervised whilst using this area at specific times throughout the day.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. Fruits and vegetables were available, and patients could store their own food in the fridge in the communal areas. Staff took account of patients' preferences.

Patients on Hardy Ward had access to a kitchen and were encouraged to prepare their own meals. Patients had cupboard space to store food and food stored in fridges was labelled with a date and checked regularly by staff.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Where appropriate, staff supported patients with activities outside the service, such as work, education and family relationships. For example, the service had links with the voluntary services, and some patients were involved in volunteering roles.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff helped patients to stay in contact with families and carers.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The wards were accessible by lift. Information on how patients could obtain accessible information was displayed on the notice board on the wards along with information about interpreting and translation services available.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service celebrated the diversity of staff and patients. The service was celebrating black history month.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. For example, the service could provide Kosher, Halal and vegetarian meals.

Patients had access to spiritual, religious and cultural support. The service had a multi-faith room within the hospital for patients to use.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

At the last inspection in November 2021, complaint investigations did not record details of the investigation or outcome. At this inspection, this was no longer the case. Managers investigated complaints appropriately. We reviewed five complaints and all five complaints had received an acknowledgement and had been reviewed promptly within timescales. Outcomes were shared in team meetings.

Patients, relatives and carers knew how to complain or raise concerns. Patients and carers told us they felt able and safe to raise concerns or complaints to staff.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers reported learning from complaints discussed at the monthly clinical governance meetings.

Requires Improvement

Forensic inpatient or secure wards

Are Forensic inpatient or secure wards well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders had the skills, knowledge and experience to perform their roles. The hospital director, the consultant forensic psychiatrist and the clinical services manager carried out the main leadership roles within the hospital. However, at the time of the inspection, the clinical services manager had just left their post, and there were no active plans to recruit into the post. The clinical service manager was responsible for ensuring key safety and quality processes were in place, such as daily clinical audits and regular supervision took place. To ensure these responsibilities were executed, the registered manager told us they were planning to deliver some of these key tasks and to also delegate some of these tasks to the team leads. They had approval to recruit a locum clinical administrator to support with associated paperwork.

Leaders demonstrated a good understanding of the services they managed. They could explain how the team were working to provide good quality care. During our inspection the registered manager demonstrated a good understanding of patients, the staff team and most matters relating to the provision of the service.

Leaders were visible in the service and approachable for patients and staff. Staff reported they could raise any concerns they had with them. We saw that managers responded immediately to rectify urgent issues that emerged during the inspection.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The provider's values were culture, integrity, quality, growth, safety and encouragement. Leaders incorporated the values in all aspects of the running of the service. Leaders told us that the provider's vision was to promote and share excellence, encourage learning and cross working between services, reduce restrictive practice and to become a learning organisation.

The provider's strategy was set to change. Following our inspection, we were informed that the hospital was moving away from the forensic low secure contract with the South London Partnership in 2023, to a model of spot purchasing. The provider planned to move towards a rehabilitation clinical model, rather than forensic.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. However, there had been new appointments to the multi-disciplinary team, and the staff team still needed support to develop an effective working culture. Leaders recognised this and had plans in place to support the staff culture of care.

Requires Improvement

Forensic inpatient or secure wards

Staff told us they felt respected, supported and valued. They could raise concerns without fear. Staff told us they felt positive and proud about working for the provider and their team, and there were no reports of a 'poor' culture or bullying / harassment.

The service was still embedding its leadership team. At the last inspection in November 2021, the service had been through a difficult period and key members of the MDT had all left the service around the same time, and the new MDT were in the process of establishing themselves. At this inspection, there were again new appointments of key members of the MDT, who were in the process of establishing themselves, and the staff team still needed support to develop an effective working culture. Leaders recognised the need to support the team culture and the chair from InMind visited the site fortnightly to provide support to staff and answer questions. The forensic psychologist had arranged for their external supervisor to visit the service twice a month to provide reflective practice. The 'staff culture of care' remained amber on the site improvement plan.

Staff knew how to use the whistle-blowing process and about the role of the Speak up Guardian. There was a poster on the wards informing staff about the provider's Speak up Guardian.

Managers dealt with poor staff performance appropriately when needed.

Staff had yearly appraisals. Appraisals included conversations about career development and training needs. They discussed how staff could be supported to achieve those development goals.

The provider recognised staff success within the service. The registered manager spoke about an example of recognising and celebrating staffs' hard work.

Governance

Our findings from the other key questions demonstrated that governance processes had improved since our last inspection, and that performance and risk were mostly managed well. However, there had been some recent gaps in the oversight of quality and safety, including risk assessments and care plans not being updated following change in risk and a lack of blood glucose calibration testing. Alongside this, the provider had been slow to make improvements when issues had been identified, and the service had not followed policy in ensuring there was a local procedure to monitor drugs liable for misuse.

At the last inspection in November 2021, the hospitals governance systems had failed to identify or appropriately address a range of quality and safety issues: ligature risks and blind spots were not always identified and managed; personal evacuation plans had not been completed; facemasks, which were mandatory at the time, were not always being worn; some mandatory training courses had low completion rates; medicines were not always managed safety; and there were gaps in staffing. At this inspection, there had been good progress made with some of the issues: ligature and environmental risk assessments were in place; personal emergency evacuation plans had been completed; there had been improvements in staffing and mandatory training completion; medicines were in date and fridge temperatures appropriately managed; and, there was now good safeguarding processes. However, some of these issues were still outstanding: there was a records to demonstrate blood glucose testing kit calibration; risk assessments and care plans were still not updated after change in risk; and not all nursing staff had received medicine competency training. Alongside this, we also found new issues with quality and safety, for example, a lack of monitoring of drugs liable for misuse and slow action to ensure all staff were up to date with fire evacuation training.

When this was raised with the registered manager, we were informed that since the clinical services manager had handed their notice in over a month ago, some of the quality checks they should have carried out lapsed. The registered manager planned to delegate some of the governance quality checks to the two team leads to make sure these checks happen now the clinical services manager post was vacant. There were no plans at the time of the inspection to advertise into the post.

At the last inspection in November 2021, governance meetings, nurse and team meetings were not happening regularly. At this inspection, this was no longer the case and governance meetings, nurse and team meetings happened monthly, with a clear framework of what must be discussed.

At the last inspection in November 2021, it was not always clear who was progressing or overseeing certain actions to improve the service. At this inspection, this had improved. A quality improvement manager employed by the provider spent 2 days a week in the service and supported the team to make improvements in quality and safety. A number of improvement action plans had been brought together in a site improvement plan. The plan was reviewed regularly. There was clearly recorded ownership of actions on the plan. Actions were not marked as completed until there was evidence that changes had been embedded.

The service had undergone an external independent review of the service in April 2022. This identified a number of areas for improvement. A follow up review had been undertaken in September 2022. There service had not completed all necessary actions. The review concluded that 22% of identified actions had been completed, 32% partially completed and 46% not completed.

Staff understood the arrangements for working with other teams, both with the provider and external to meet the needs of the patients. For example, the hospital director attended monthly meetings with the other hospital directors across Inmind where they discussed any concerns and shared learning.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff maintained and had access to the risk register. Staff at ward level could escalate concerns when required. This register was stored on the shared drive which all staff had access to. The risk register was updated at the governance meetings.

Staff concerns matched those on the risk register. For example, staff concerns around staffing levels and the use of paper records to document care.

The service also used their site development improvement plan to record risks and how they were working to improve them. The quality improvement manager had responsibility over this document.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. The service had a business continuity plan which covered a range of incidents and recovery plans.

Information management

The service used systems to collect data from wards that were not over-burdensome for frontline staff. The ward collected information relating to performance, such as length of stay and delayed discharges. This collection of information did not impact the ward team.

Requires Improvement

Forensic inpatient or secure wards

At the last inspection in November 2021, information such as how many hours of meaningful activity patients received was not being collected. At this inspection, this was now being collected and routinely reported to commissioners.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

The hospital's note system was both electronic and paper based. We found the electronic records were up to date and comprehensive, whilst the paper records were often not updated following change in need or risk. Managers acknowledged the downfalls of paper records, and this issue was on the hospital's risk register. The provider had plans to move towards only electronic record systems in the first quarter of 2023.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. The pharmacist completed monthly and quarterly medicines audits and produced a summary report and sent these to managers for discussion at the monthly governance meetings.

Information was gathered and collated for governance meetings, both within the hospital and for their commissioners. This information was presented in a report style document.

Staff knew when they needed to make notifications to external bodies, including the Care Quality Commission.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff had access to up-to-date information about the work of the provider through team meetings and emails. Patients were kept up to date through regular community meetings. Due to the small size of the hospital, managers were able to meet with staff and patients regularly. The chair from InMind had recently started to visit the hospital to engage with staff and answer questions about the provider. Carers were offered the opportunity to keep up to date with the service, via attending a virtual carers forum online once a month.

Patients and carers had opportunities to give feedback on the service they received. For example, patients could raise issues during weekly community team meetings, in their ward rounds and care programme approach (CPA) meetings. Carers could raise issues during monthly carers forums, or to staff and management as required.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. For example, staff reported that it would be useful for reflective practice to start again post-pandemic. The forensic psychologist had put plans in place to this to re-start. We also saw where patients raised issues in the community meeting minutes, that there was evidence that these had been resolved.

The hospital manager engaged with external stakeholders such as the South London Partnership to deliver effective care and treatment.

Requires Improvement

Forensic inpatient or secure wards

Learning, continuous improvement and innovation

The service had started to develop its approach for making improvements. At our last inspection in November 2021, the service did not use any structured quality improvement model to improve and develop the service. At this inspection, the provider had taken a number of steps to improve the service. For example, a quality improvement manager was in place to take responsibility of the site development improvement plan, and they were able to support the team to make improvements in quality and safety. The quality improvement manager acknowledged there was still work to do, particularly in relation to embedding improvements, increasing service user involvement, ensuring learning from audits was followed up and improving record keeping.

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. For example, there had been improvements in security at the service. The security lead took an overview of security and had created a documented process and procedure leading to a greater consistency of security checks. Pictures were used to help staff identify contraband consistently.

Wards participated in accreditation schemes relevant to the service and learned from them. The service was a member of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services and received regular reviews.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not have a local procedure in place to safely monitor drugs liable for misuse (DLM), which was against the provider's medicines management policy. Not all staff were trained and assessed as competent to complete medicines tasks Risk assessments were not always up to date and did not outline how staff would mitigate identified risks The service was unable to provide assurance that the blood glucose testing kits were suitable for use. The service had been slow to ensure all staff were compliant with fire evacuation training. The service had identified the training need in 2021, but compliance remained low at 51%.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not always have robust governance systems to ensure the quality and safety of the service. There had been a recent lapse in some quality assurance processes and some actions from the previous inspection remained outstanding or had taken a long time to action.