St Andrew's Healthcare - Mens Service

Quality Report

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Date of inspection visit: 15 to 19 May and 1 June 2017
Date of publication: 07/08/2017

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

Ratings

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

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.

Summary of findings

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

Overall summary

We rated St Andrew's men's services as inadequate because:

- The provider had not addressed the issues identified in the June 2016 inspection whereby staff were trained in two types of managing aggression and restraint. It was still the case that staff were trained in two different types of managing aggression and restraint. This posed a risk to staff and patients if staff were following two different approaches. In the May 2017 inspection we identified the following concerns.
- Some of the wards were not clean or safe. Ferguson ward was dirty and had plaster falling off the walls. This posed an infection control risk. The standards of cleanliness were poor on three wards and the issue had not been identified through the provider's own monitoring system. In addition, the provider's ligature audits had not identified how to mitigate risks posed by potential ligature anchor points. This problem was compounded by the fact that staff did not always update the risk assessments of individual patients following an incident.
- Staffing levels were poor in most clinical areas. Although staff establishment numbers were met at the beginning of a shift, they were not increased when more staff were needed to undertake patient observations or because staff were required to help out on other wards. Staff shortages meant that patient activities and leave were sometimes cancelled. Also, shifts often had one qualified member of nursing staff, especially at night, which meant that staff could not take breaks. Agency nurses employed to make up the shortfall did not all have access to the electronic prescribing system to administer medicines. This meant that a member of staff from another ward had to come to assist.
- There was a high turnover of staff indicating staff retention as a problem. Turnover was 32% in one forensic ward, 22% in the psychiatric intensive care unit, and 20% on a rehabilitation ward.
- The standard of record keeping was poor in forensic and rehabilitation services. We identified that retrospective entries had been made in a seclusion record. We brought this to the attention of a manager. Handovers in forensic and rehabilitation services were poor. There was no structure, pieces of paper were used to write on and patients were not discussed in handover until the inspection team pointed this out. Records did not always document discussion around a patient's capacity. Record entries in the learning disabilities service were sometimes punitive in nature. Records of ongoing physical healthcare monitoring were poor in all but older people's and learning disabilities services. Risk assessments did not identify all risk factors.
- The long term segregation policy did not meet the Mental Health Act code of practice in respect of review requirements. For example, the long term segregation policy allowed for the nurse in charge, rather than an approved clinician, to review the patient daily, and allowed for another division of the hospital (rather than an external hospital) to undertake the three monthly reviews. We found that staff were confused about what constituted seclusion and long term segregation. Many staff described patients as being in 'extra care' when in fact they were either secluded or in long term segregation.
- A theme from discussions with all staff groups, including medical, nursing, social workers, and psychology staff, was that admissions were not always clinically led. We were given examples of when a clinician's decision had been overridden by non clinicians. This posed a risk of inappropriate admissions.
- From information given to us on inspection, both in groups and individually, we formed the view there was an oppressive culture in these services. Different staff groups, including nursing staff, medical staff, psychologists, and social workers, reported a fear of speaking up in case of reprisals.

However:

Summary of findings

- In older adults there was effective provision of physical healthcare. Staff had received specific training to carry out their role, such as dementia training and end of life care. Staff received regular supervision and appraisals.
- The provider had taken action to address the shortage of staff. It had run many recruitment fairs in an attempt to attract staff to work at St Andrew's and staff were being recruited. The Aspire programme enabled healthcare assistants to become qualified nurses with a bursary provided by St Andrew's Healthcare.
- There was an emphasis on positive behaviour support planning and a continued move to reduce the use of restraint, including prone restraint. The use of restraint was monitored by the restrictive practice monitoring group which met monthly to review the use of restraint in all services. Data showed a downward trend in the use of restraint, with the provider reporting a reduction in restraint by 32%, and a reduction in the use of prone restraint by 38%. According to the provider, the use of seclusion had decreased by 17%. Staff in learning disabilities completed detailed positive behavioural support plans with patients that included triggers and ways in which staff and patients could reduce negative behaviours.
- Patients knew how to make a complaint and there were effective systems in place to support managers to investigate complaints and identify an outcome.
- Staff supported patients with physical health issues. Staff completed annual healthcare assessments with patients and supported access to specialist services, where required.
- There were weekly manager and matron meetings to review issues, monthly quality and safety meetings which included the managers, clinicians, and compliance manager. There were weekly bed management meetings to review bed numbers.
- At the time of the inspection, a new leadership team for the service had just been put in place who were actively addressing the concerns within the service. The recently appointed service director had identified and understood the improvements which were required in the men's pathway. They had introduced a local audit two weeks before the inspection and piloted on one ward. The aim of this was to have more immediate action taken when issues were identified.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	**Good** 	Heygate ward is a ten bedded ward.
Forensic inpatient/ secure wards	**Inadequate** 	Robinson ward is a medium secure ward with 17 beds. Fairbairn ward is a medium secure ward with 17 beds for people with a hearing impairment. Prichard is a medium secure ward with 16 beds.
Long stay/ rehabilitation mental health wards for working-age adults	**Inadequate** 	Ferguson ward is a locked rehabilitation ward with 15 beds. Church ward is a locked rehabilitation ward with ten beds. Fenwick ward is a locked rehabilitation ward with ten beds.
Wards for older people with mental health problems	**Good** 	Cranford ward is a medium secure ward with 17 beds. Foster ward is a low secure ward with 15 beds.
Wards for people with learning disabilities or autism	**Requires improvement** 	Hawkins ward is a medium secure ward with 16 beds. Mackaness ward is a medium secure ward with 16 beds. Harlestone ward is a low secure ward with 20 beds. Naseby ward is 15 bedded ward for men with mild to borderline learning disabilities.

Summary of findings

Contents

Inadequate

St Andrew's Healthcare

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults; Wards for older people with mental health problems; Wards for people with learning disabilities or autism;

Summary of this inspection

Background to St Andrew's Healthcare - Mens Service

St Andrew's Healthcare Northampton has been registered with the Care Quality Commission since 11 April 2011. The services have a registered manager and a controlled drug accountable officer. The registered locations at Northampton are adolescent services, men's services, women's services and acquired brain injury (neuropsychiatry) services.

Northampton is a large site consisting of more than ten buildings, more than 50 wards, and has 659 beds.

St Andrew's Healthcare also has services in Nottinghamshire, Birmingham and Essex.

These locations at St Andrew's Healthcare Northampton have been inspected 20 times. The last comprehensive inspection was in June 2016. There was a focused inspection in February 2017 which looked at the use of restraint in learning disabilities services.

Patients receiving care and treatment at St Andrew's Healthcare follow care pathways. These are women's mental health, men's mental health, autistic spectrum disorder, adolescents, neuropsychiatry, and learning disabilities pathways.

The following services were visited on this inspection:

Forensic inpatient/secure wards:

St Andrew's Healthcare, Northampton, provides mental health forensic inpatient/secure services for men and women of working age. All patients receiving treatment in this service are detained under the Mental Health Act (1983).

There are nine wards at the Northampton site providing forensic inpatient/secure services. These include men's and women's services. All wards are single sex and follow care pathways as patients progress with their recovery.

We inspected the following wards in men's services:

• Robinson ward is a medium secure ward with 17 beds.

• Fairbairn ward is a medium secure ward with 17 beds for people with impaired hearing.

• Prichard ward is a medium secure ward with 16 beds.

Long stay / rehabilitation wards for working age adults:

There are three wards providing rehabilitation support to patients. We inspected:

- Ferguson ward provides support for up to 15 male patients in a locked rehabilitation environment. Some time was spent on this ward during the follow up visit completed 1 June 2017.
- Church ward provides support for up to 10 male patients in a locked rehabilitation environment (previously Ashby ward). Some time was spent on this ward during the follow up visit completed 1 June 2017.
- Fenwick ward provides support for up to 10 male patients in a locked rehabilitation environment (Previously Ashby ward). This ward was inspected as part of the follow up visit completed 1 June 2017.

Church and Fenwick wards opened approximately one month before the inspection visit. Staff and patients on these wards moved from Ashby ward, therefore some of the data used in the report is not broken down into the two separate wards.

Wards for people with learning disabilities or autism:

The services for patients with learning disabilities and autism provide inpatient accommodation for patients with learning disabilities over the age of 18 years. We inspected the following wards:

- Hawkins ward, a 16 bed medium secure service for men with learning disabilities and forensic challenging behaviour.
- Harlestone ward, a 20 bed male low secure ward for people with autistic spectrum disorder.
- Naseby ward, a 15 bed service for men with mild/ borderline learning disabilities.
- Mackaness ward, a 16 bed a male medium secure ward for people with autistic spectrum disorder.

The learning disabilities (LD) pathway provides care and treatment for adults with mild to moderate learning disabilities and other neuro-developmental disorders

Summary of this inspection

who have offended or display behaviour which challenges. People in the autism services have co-existing conditions such as mental and physical illness or additional developmental disorders such as personality disorder which put themselves or others at risk.

Acute wards for adults of working age and psychiatric intensive care units:

• Heygate ward (previously Sherwood) is a psychiatric intensive care unit with 10 beds.

Wards for older people with mental health problems:

• Foster is a low secure ward with 15 beds for males over the age of 45 years.

• Cranford is a medium secure ward with 17 beds.

This was a focused announced inspection, looking at the key questions which had been rated as requires improvement in the June 2016 inspection, with a follow up unannounced visit on 1 June 2017.

Our inspection team

Team leader: Margaret Henderson

The team that inspected this service comprised one Care Quality Commission inspection manager, three Care Quality Commission inspectors, five specialist nurse advisors, one consultant psychiatrist, a national professional advisor in learning disabilities and two experts by experience. Experts by experience are people who have experience of using services or for caring for someone who has used services.

The team would like to thank all those who met and spoke with them during the inspection and who shared their experiences and perceptions of the quality of care and treatment at the service.

Why we carried out this inspection

We undertook this inspection to find out whether St Andrew's Healthcare men's services in Northampton had made improvements to their forensic, rehabilitation, psychiatric intensive care unit, and older people services, since our last inspection at Northampton in June 2016. We also re-inspected the learning disabilities services.

When we last inspected the Northampton site in June 2016, the overall rating for this location was requires improvement. We rated the safe and effective key questions as requires improvement for forensic services. We rated the effective key question as requires improvement for rehabilitation. We rated the safe and responsive key questions as requires improvement for the psychiatric intensive care unit and the effective key question as requires improvement for the older adults service. In June 2016, we rated the learning disabilities core service as good across all key questions. We re-inspected the learning disabilities service in February 2017 owing to concerns raised around the use of restraint and re-inspected all key questions in May 2017.

Following the June 2016 inspection, we told the provider to take the following actions:

- The provider must ensure that environments are safe, clean and promote the privacy and dignity of patients. Staff must promote privacy and dignity in their practice.
- The provider must ensure all patient risk assessments and care plans include how staff will manage specific environmental ligature risks.
- The provider must ensure that staff complete appropriate physical checks and care for patients.
- The provider must ensure patients' hydration and nutrition needs are met and recorded.
- The provider must ensure there are sufficient numbers of suitably qualified, competent, skilled, and experienced persons deployed to meet the needs of the service.
- The provider must make sure that mental capacity assessments are completed and that they are decision

Summary of this inspection

specific. The provider must ensure there is evidence of documented discussion with the patient when decisions are made regarding a patient's capacity to make decisions.

These were in relation to the following regulations:

Regulation 10 Dignity and respect

Regulation 11 Need for consent

Regulation 12 Safe care and treatment

Regulation 14 The nutritional and hydration needs of services users must be met

Regulation 15 Premises and equipment

Regulation 18 Staffing

We also said the provider should:

- ensure that blind spots are reduced and the risk mitigated on all wards
- ensure that patient care plans can be easily read by all patients or available in different formats, and demonstrate individual patient involvement or record how patients are supported with the process
- ensure legal detention paperwork is uploaded onto the electronic care records promptly for staff to access
- ensure there is consistency in relation to where information is kept on the electronic care records
- ensure that governance and team performance information is shared with all the ward team in addition to the ward management team.

We have identified the issues which remain later in this report, the provider had addressed some but not all of these actions from the June 2016 inspection.

How we carried out this inspection

We carried out this inspection as a focused, follow up inspection. We did not inspect the safe key question for rehabilitation and older peoples. We did not inspect the effective key question for the psychiatric intensive care unit. We only inspected the caring key question for learning disabilities. We did not inspect the responsive key question for forensic, rehabilitation and older people's services. We inspected the well led key question for all services.

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

During the inspection visit, the inspection team:

- held staff focus groups the week before and during the inspection
- visited 13 wards at the hospital, looked at the quality of the ward environment, and observed how staff were caring for patients
- spoke with 46 patients who were using the service
- interviewed the nurse manager for each of the wards
- interviewed the senior management team for each service
- spoke with 71 other staff members; including doctors, nurses, healthcare assistants, clinical and forensic psychologists, trainee psychologists
- looked at 70 care records
- reviewed 75 prescription charts and inspected medicines management
- attended six handovers and one multidisciplinary meeting
- looked at a range of policies, procedures and other documents relating to the running of the service
- inspected seclusion facilities and reviewed seclusion records.

What people who use the service say

We spoke with 46 patients and three carers.

Patients we spoke with told us they enjoyed the activities and education courses but said these were cancelled if there were not enough staff. They told us that regular staff on the wards offered them support and practical advice in relation to management of their mental health and wellbeing. However, they said use of bank and agency

Summary of this inspection

staff could result in inconsistent treatment, and staff unfamiliar with their needs. Patients said staff tried hard to help and were caring and said they were involved in their care.

Patients told us they knew how to make a complaint, and how to access the advocacy service. Patients said they used the weekly community meetings as a forum for raising concerns and making suggestions about service improvement. Some patients said they felt unsafe on the wards and said there was a gang culture. Patients expressed frustrations in relation to the smoking ban and the impact this has had on their quality of life.

Some patients spoke about their experiences of restraint and seclusion. Patients understood the need for restraint, but at times reported staff to be heavy handed in their approach.

Patients in learning disabilities told us that staff were kind and caring and knew them well.

Carers told us they thought the management of the no smoking policy was not done well. They identified low staffing as an issue. They said that on visits there was a delay in them receiving their passes at reception to be able to visit the wards.

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?

Inadequate

We inspected this key question for forensic services, learning disabilities service and the psychiatric intensive care unit.

We rated these services as inadequate for safe because:

- The provider had not addressed the issues identified in the June 2016 inspection whereby staff were trained in two types of managing aggression and restraint. It was still the case that staff were trained in two different types of managing aggression and restraint. This posed a risk to staff and patients if staff were following two different approaches. In the May 2017 inspection we identified the following concerns.
- Some of the wards were not clean or safe. Ferguson ward was dirty and had plaster falling off the walls. This posed an infection control risk. The standards of cleanliness were poor on three wards and the issue had not been identified through the provider's own monitoring system. Also, the provider's ligature audits had not identified how to mitigate risks posed by potential ligature anchor points. This problem was compounded by the fact that staff did not always update the risk assessments of individual patients following an incident.
- Staffing levels were poor in most clinical areas. Although staff establishment numbers were met at the beginning of a shift, they were not increased when more staff were needed to undertake patient observations or because staff were required to help out on other wards. Requests for additional staff were made in advance if possible, however, when staff were sourced at short notice they could lack familiarity with the ward environment and patient group. Staff shortages meant that patient activities and leave were sometimes cancelled. Also, shifts often had one qualified member of nursing staff, especially at night. This meant that staff could not take breaks. Agency nurses employed to make up the shortfall did not all have access to the electronic prescribing system to administer medicines.This meant that a member of staff from another ward had to come to assist.
- There was a high turnover of staff indicating staff retention as a problem. Turnover was 32% in one forensic ward, 22% in the psychiatric intensive care unit, and 20% on a rehabilitation ward.
- We identified some issues around medicines management in forensic, rehabilitation, and learning disabilities services. There were out of date items, gaps in prescription charts, and lack of

fridge temperature monitoring.We found equipment which had passed its expiry date or safety testing date. For example, out of date oxygen tubing on the psychiatric intensive care unit, empty oxygen cylinders, expired glucose monitoring strips. A nebuliser on Ferguson ward was passed its safety testing date and fridge temperatures were not addressed when outside of correct range. In the learning disabilities service an oral medication had been recorded as given in the intramuscular section of the chart. This could lead to an error in administration. One patient was not given insulin when prescribed (incorrect time); this could cause further complications of their diabetes.

However:

- The provider had run many recruitment fairs in an attempt to attract staff to work at St Andrew's and staff were being recruited.
- The management of self administration of medicines in learning disabilities services was effective.
- There was an emphasis on positive behaviour support planning and a continued move to reduce the use of restraint, including prone restraint. Staff in learning disabilities completed detailed positive behavioural support plans with patients that included triggers and ways in which staff and patients could reduce negative behaviours.
- Most staff demonstrated awareness of how to use the electronic recording system for reporting incidents. From patient records reviewed, where there had been an incident the records included a reference number from the electronic incident recording system, resulting in an audit trail.
- Nurse managers explained about the need to ensure openness and transparency, explaining to patients where applicable when things go wrong.

Are services effective?

Requires improvement

We inspected forensic services, rehabilitation services, older people's service and learning disabilities services.

We rated effective as **requires improvement** because:

- The standard of record keeping was poor in forensic and rehabilitation services. We identified that retrospective entries had been made in a seclusion record. We brought this to the attention of a manager. A staff member signed a record for something for a time they had not been on duty. Handovers were poor in forensic and rehabilitation services. There was no structure, pieces of paper were used to write on and patients

were not discussed in handover until the inspection team pointed this out. Records did not always document discussion around a patient's capacity in forensic and rehabilitation services. Records of ongoing physical healthcare monitoring were poor in all but older people's services and learning disabilities services.

- The long term segregation policy did not meet the Mental Health Act code of practice in respect of review requirements. For example, the long term segregation policy allowed for the nurse in charge, rather than an approved clinician, to review the patient daily, and allowed for another division of the hospital (rather than an external hospital) to undertake the three monthly reviews. We found that staff were confused about what constituted seclusion and long term segregation. Many staff described patients as being in 'extra care' when in fact they were either secluded or in long term segregation.

However:

- In older adults there was effective provision of physical healthcare. Staff had received specific training to carry out their role, such as dementia training and end of life care. Staff received supervision and appraisals.
- The Aspire programme enabled healthcare assistants to become qualified nurses with a bursary provided by St Andrew's Healthcare.
- There was an emphasis on positive behaviour support planning and a continued move to reduce the use of restraint, including prone restraint. Staff in learning disabilities completed detailed positive behavioural support plans with patients that included triggers and ways in which staff and patients could reduce negative behaviours. Staff in learning disabilities services supported patients with physical health issues. Staff completed annual healthcare assessments with patients and supported access to specialist services, where required.
- We noted improvement in the Mental Health Act administration since the inspection in June 2016.

Are services caring?

Good

Following our inspection in June 2016, we rated the services as good for caring. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings for forensic, rehabilitation, psychiatric intensive care unit and older people's wards.

We only inspected this key question in learning disabilities.

We rated caring in learning disabilities as **good** because:

Summary of this inspection

• Staff involved patients, families and carers in care and treatment. Staff involved patients in their care plan and staff updated families and carers when risk changed.

• Patients had access to independent advocacy and there were examples of the advocate supporting patients to make complaints.

However:

- Most interactions that we observed were of staff supporting and engaging with patients in an active and positive manner. Although this was mostly true on Harlestone ward, we did observe two instances of staff taking a long time to acknowledge requests from patients for assistance.

Are services responsive?

Good

Following our inspection in June 2016, we rated services as good for responsive, with the exception of the psychiatric intensive care unit. We inspected the psychiatric intensive care unit and learning disabilities service for this key question.

We rated responsive as **good** because:

- In the psychiatric intensive care unit there was full disabled access to the ward and patients' en suite bathrooms provided access for wheelchairs. There were additional disabled bathrooms on the ward. There was a full range of rooms available to support patients' treatment and care.
- Staff provided patients with activities seven days a week.
- Ward staff told us that leaflets in other languages could be obtained on request. Complaints posters and leaflets were visible on the wards. Patients knew how to complain and there were systems in place to support the investigation of complaints.
- There was a chaplaincy service and access to spiritual leaders for other faiths on request.
- The environment was appropriate for the needs of the patients, including sensory rooms and low stimulus environments in learning disabilities.
- Patients returned to their own bed after any section 17 leave. If patients risk increased their mental health deteriorated, staff made appropriate referrals to other wards that offered more intensive support or higher levels of security.

However:

Summary of this inspection

- A theme from discussions with all staff groups was that admissions were not always clinically led. We were given examples of when a clinician's decision had been overridden by non clinicians. This posed a risk of inappropriate admissions.
- Psychology input was available in the psychiatric intensive care unit but had been reduced due to limited psychology hours.

Are services well-led?

Inadequate

We inspected all services for this key question.

We rated well led as **inadequate** because:

- The delivery of high quality care was not assured by the leadership, governance or culture in place. The monitoring and governance processes were not effective enough to ensure issues were picked up in a timely manner. We identified a lack of effective monitoring and awareness of infection control, poor cleanliness, and environment issues. A lack of effective monitoring of record keeping standards particularly in relation to seclusion and long term segregation. There was a lack of effective risk management processes in relation to ligature points and individual patient risks.
- The provider had not addressed the concerns about the environment, record keeping, staffing, staff supervision and staff training in the management of aggression and in use of physical restraint identified in the June 2016 inspection.
- There was a high turnover of staff indicating staff retention as a problem. Turnover was 39% in one forensic ward, 24% in the psychiatric intensive care unit and 20% on a rehabilitation ward. Staff shortages meant that patient activities and leave were sometimes cancelled. Also, shifts often had one qualified member of nursing staff, especially at night.
- The long term segregation policy did not meet the Mental Health Act code of practice in respect of review requirements.
- A theme from discussions with all staff groups was that admissions were not always clinically led. We were given examples of when a clinician's decision had been overridden by non clinicians. This posed a risk of inappropriate admissions.
- From information given to us on inspection, both in groups and individually, we formed the view there was an oppressive culture in these services. Different staff groups, including nursing staff, medical staff, psychologists, and social workers, reported a fear of speaking up in case of reprisals.
- There was a lack of an effective regular line management process for recording staff performance and support. Line management supervision was given when there was an issue rather than on an ongoing and supportive basis.

Summary of this inspection

However:

- The provider had a recruitment strategy and was running recruitment fairs to attract staff to St Andrew's. The Aspire programme enabled healthcare assistants to become qualified nurses with a bursary provided by St Andrew's Healthcare. There were staff who had been appointed and were waiting to begin work at St Andrew's.
- There was an emphasis on positive behaviour support planning and a continued move to reduce the use of restraint, including prone restraint. This was monitored by a restrictive practice monitoring group. Data showed a downward trend in the use of restraint, with the provider a reduction in restraint by 32%, and a reduction in the use of prone restraint by 38%. The use of seclusion had decreased by 17%.
- Foster and Cranford wards were part of the quality network for inpatients accreditation for the men's secure service. Occupational therapists working within the forensic, male pathway worked to the Model of Creative Ability accreditation framework.
- At the time of the inspection, a new leadership team for the service had just been put in place who were actively addressing the concerns within the service. There were weekly manager and matron meetings to review issues and monthly quality and safety meetings which included the managers, clinicians and compliance manager. There were weekly bed management meetings to review bed numbers. A local audit had been introduced two weeks before the inspection and piloted on one ward in the forensic service. The aim of this was to have more immediate action taken when issues were identified.

Detailed findings from this inspection

Mental Health Act responsibilities

- The provider's records showed that 89% of staff in the men's pathway had completed training in the Mental Health Act training.
- Mental Health Act paperwork was in order for the records we reviewed, with patient leave entitlement clearly documented and outcomes from leave placed in progress notes. Patient's had their rights under the Mental Health Act explained to them, and reviewed every six months, with a reminder in place on the electronic records system. Patient medication records contained T2 and T3 paperwork in relation to consent to treatment.
- Patients had access to advocacy and independent mental health advocates based on the hospital site for support with complaints and tribunals. However, we found minimal involvement of independent mental health advocacy with patients in long term segregation. Although, we did find that weekly multidisciplinary reviews had been undertaken in the majority of cases.
- On the ward for the hearing impaired, Fairbairn ward, patients accessed information on DVDs and posters explaining their rights under each section of the Mental Health Act.
- Nurse managers told us that the Mental Health Act administration team completed audits of Mental Health Act paperwork. Staff could seek advice when required.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider's records showed that 82% of staff in the men's pathway had completed training in the Mental Capacity Act. Nurse managers on Robinson and Prichard did not identify any patients assessed to lack mental capacity to make decisions in relation to their care and treatment. However, on Fairbairn ward specialist assessments were completed, tailored to the needs of patients with hearing impairment and potential gaps in their education. The quality of some consent to treatment records lacked detail in relation to the patient's ability to weigh up and retain information related to the question.
- Capacity assessments were discussed during ward rounds, with the responsible clinician and staff. Managers would circulate an updated feedback form to staff weekly. We saw patient note entries where capacity was discussed with the patient. Care plans reflected patient views around medication, interventions and decisions.
- Staff on Church ward identified patients assessed to lack mental capacity to make decisions in relation to aspects of their care and treatment. One patient on Foster ward had an authorised Deprivation of Liberty Safeguards application.
- The provider carried out audits into the adherence to Mental Capacity Act and action was taken where identified. Staff could access the policy and advice when required.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Forensic inpatient/ secure wards	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate
Long stay/ rehabilitation mental health wards for working age adults	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate
Wards for older people with mental health problems	N/A	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Overall	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate

Acute wards for adults of working age and psychiatric intensive care units

Good

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

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Requires improvement

Safe and clean environment

- The ward layout allowed staff to observe all parts of the ward and closed circuit television was in use.
- There were ligature points in bedrooms, en suite bathrooms and disabled toilets. A ligature point is a place to which patients intent on self-harm might tie something to strangle themselves. The ligature risk audit stated that individual risk assessments were completed on all patients but no actions were documented or completed under the action required column of the risk audit. The ward manager told us that the ligature risk audit was not on the risk register.
- The clinic room was clean and medicines were stored securely. Stock and individually dispensed medicines were administered in line with local policies. We found that the fridge temperature was outside accepted range and appropriate action regarding temperatures was not documented on three occasions within seven days. Emergency medicines were accessible to staff. Out of date equipment was found in the emergency equipment bags.
- The seclusion room had closed circuit television allowing clear observation of the seclusion room and the adjoining bathroom. We observed that there was a clock in the seclusion room and the two way communication system was working.
- All ward areas were clean, well-furnished and well maintained.
- There were handwashing signs in place and anti-bacterial gel at the entrance to the ward.
- Equipment was safety tested, clean and clean stickers were visible and in date.
- We examined cleaning records and saw that they were up to date and the environment was cleaned regularly.
- All staff had safety alarms and a nurse call system was in place. All inspection staff were given safety alarms prior to attending the ward.

Safe staffing

- At the time of inspection there was 10 whole time equivalent (WTE) qualified nurses, two qualified nurse vacancies and 15 WTE nursing assistants with no vacancies.
- For the 12 months prior to the inspection the number of bank or agency shifts used to cover sickness, absence or vacancies was 738. The number of shifts that have not been filled by bank or agency staff where there was sickness or vacancies was 120 (16%). The staff sickness rate was 4.5 % over the 12 months prior to the inspection. The staff turnover rate was 22 % over the same period.
- The number and grade of nurses required was estimated according to the patient mix and the number of patients on increased levels of observations. The ward manager told us that where a patient required 2:1 observations or seclusion then the staffing number would increase. The provider supplied information stating that nurse managers were able to view current establishment and vacancies and were able to create requests for extra staff based on the needs of the service

at the time. The daily staffing census captured daily staffing. There was a daily operations meeting that also monitored staffing across the site. The number of nurses required matched the number on all shifts.

- The ward largely used bank staff that were familiar with the ward, and patients. Agency staff were used dependant on need. The provider supplied data indicating that across the service the average use of bank or agency staff between 1 January and 31December was 6.5%.
- We observed that a qualified member of staff was present in the communal areas of the ward at all times during inspection.
- Patients told us that they were able to have regular one to one time with their named nurse. The ward manager used an audit tool to check weekly that patients had received their one to one and if they had refused then this was documented in their records.
- Escorted leave or ward activities were rarely cancelled as there was a full time activities coordinator and staff planned leave at the beginning of each day to ensure that it took place.
- We observed on two occasions that when staff activated their personal alarm for assistance, nursing staff on the ward and staff from neighbouring wards attended promptly to support colleagues.
- Staff received appropriate mandatory training and the compliance rate for this service was 100%.

Assessing and managing risk to patients and staff

- There were 99 incidents of the use of seclusion in the six months leading up to the inspection. There were no incidents of the use of long- term segregation in the same period. There were 101 incidents of the use of restraint, of those incidents of restraint 42 were in the prone position (41%). We observed staff using de-escalation techniques with patients. The use of restraint was monitored in the restrictive practice monitoring group on a monthly basis. The use of prone restraint had decreased since the June 2016 inspection from 44%. The provider reported a reduction in restraint by 32% across all services, and a reduction in the use of prone restraint by 38% and the use of seclusion had decreased by 17%.
- The team examined six patient care records. Of those, all contained an up to date risk assessment on or soon after admission and these had been regularly updated throughout the admission. Staff used a risk assessment which was unique to St Andrew's.
- We did not identify any use of blanket restrictions and the ward manager told us that staff had been working to eradicate blanket restrictions following on from the last inspection.
- There were policies and procedures in place for the use of observation. There was a dedicated room which was used to search patients in private and we saw evidence of record keeping following searches.
- We reviewed six prescription charts. Rapid tranquilisation, when used, followed National Institute for Health and Care Excellence guidelines.
- The seclusion suite had an en suite bathroom, two way communication system, clock and closed circuit television to allow staff to observe patients at all times.
- We reviewed two seclusion records. Staff did not follow policy as medical reviews were not carried out four hourly in one of the records. There was no documented report by the staff member monitoring every 15 minutes in both cases and there was not always a clear rationale for why seclusion ended.
- The provider had a safeguarding policy that staff were familiar with. Staff received training in safeguarding and were able to describe how to make a safeguarding alert and gave examples of when they had done this.
- The clinic room keys were held securely by a nurse and the room, fridge, and cupboards were kept locked. The pharmacy technician visited weekly to date check medicines and order stock medicines. Stock and individually dispensed medicines were administered in line with local policies. We found that the fridge temperature was outside accepted range and appropriate action regarding temperatures was not documented on three occasions within seven days during May 2017.
- Emergency medicines were accessible to staff. The emergency bag was found to contain oxygen tubes which had expired in March 2016. Weekly clinic checks had been completed, indicating that equipment was present and in date, the expected expiry date of the tubing was recorded as 01/2020.
- Staff explained an incident of patient developing a pressure sore and steps had been taken to minimise the risk of recurrence.

Acute wards for adults of working age and psychiatric intensive care units

Good

- There was a family room in the building for visiting to take place and the social worker carried out an assessment prior to children visiting the ward.

Track record on safety

- There were two serious incidents in the 12 months leading up to the inspection.
- The three most frequently occurring type of incident within was physical aggression and violence, sexual activity, and loss and theft/ medication. Each incident was investigated with an action plan, with the aim to prevent reoccurrence. Serious incidents were reviewed and discussed at local quality and risk group meetings.
- Staff told us that the previously more restrictive approaches had been minimised and gave the example that a patient requesting a cup of tea would be given it at any time of the day or night to try to reduce the escalation of simple issues and meet patient's wishes where possible.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and could describe what should be reported. The provider used an electronic system to record all incidents.
- All staff completed a form on the electronic recording system for all events/near misses occurring within St Andrew's sites (including the hospital grounds), as well as in the community whilst staff members were on duty, or involving patients who were under the care of St Andrew's. This involved clinical and non-clinical events, including information governance events. All staff members had access to the electronic recording system.
- We reviewed the incident log and cross referenced with patient records and found that incidents that should be reported were reported.
- Staff were aware of the Duty of candour and were open, transparent and explained to patients when things went wrong. An example was given of when a staff member wrongly allowed a patient to buy matches whilst on escorted leave. This was in contradiction to their risk assessment. Following investigation it was concluded that the staff member was wrong and both patient and staff were informed of this
- Nurse managers provided feedback on the outcome of investigations of incidents. Staff discussed the learning from incidents at daily handover and at the weekly multidisciplinary team meeting. Staff received a debrief after serious incidents and could access support from ward managers or further counselling if required.
- A patient developed a pressure sore and following investigation it was concluded that staff had focussed on his mental health to the detriment of his physical health and should in the future adopt a more holistic approach.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Following our inspection in June 2016 we rated the services as good for effective. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Following our inspection in June 2016 we rated the services as good for caring. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Acute wards for adults of working age and psychiatric intensive care units

Good

- The average bed occupancy over the last six months leading to inspection was 75%. The service was at full capacity at the time of inspection.
- Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. Nurse managers told us that people were moved or discharged at an appropriate time of the day. Discharge was not delayed for other than clinical reasons.
- In the six months leading to inspection there was one recorded delayed discharge. Information from the provider stated that delayed discharges were owing to identifying a new provider, agreeing to funding or receiving permission from the Ministry of Justice.
- Care plans referred to identified section 117 aftercare services to be provided for those who have been subject to section 3 of the Mental Health Act or equivalent Part 3 powers.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms and equipment to support treatment and care. Rooms included a clinic room, quiet room, fitness room, games room, seclusion suite, extra care area, and meeting rooms for patients and staff. There was a quiet lounge on the ward and a family ward within the building for patients to see visitors.
- We observed a patient making a private phone call in the telephone room on the ward day area. Patients had access to a large outside courtyard and patients accessing the extra care area had access to a covered outside space and fresh air.
- Patients said that the food was of reasonable quality and they chose meal options form the menu on a weekly basis. The PLACE survey score for food was 79%. Patients had access to hot drinks and snacks at any time of the day.
- Patients were able to personalise their bedrooms and we saw examples of a patient's own artwork in his room. Patients could store their belongings in a locked storage room on the ward.
- Activities were provided to patients seven days per week. There were occupational therapy group sessions provided and the ward activities timetable was displayed on the activities notice board in the lounge.

Meeting the needs of all people who use the service

- There was full disabled access to the ward and patients' en suite bathrooms provided access for wheelchairs. There were additional adapted bathrooms on the ward.
- Ward staff told us that leaflets in other languages could be obtained on request.
- We saw several different notice boards on the ward which had information on patients' legal rights, advocacy, complaints, chaplaincy service and treatment.
- Patients chose meal options in advance weekly from the menu list. There were options available to meet the religious and dietary requirements of different religious and ethnic groups.
- Patients had access to the hospital chaplaincy service and a local Imam visited the ward to see patients.

Listening to and learning from concerns and complaints

- Overall, the unit received eight complaints in the 12 months leading up to inspection. None were upheld and none was referred to the ombudsman.
- We saw complaints posters and leaflets on the wards and patients told us that they knew how to complain. None of the patients that we spoke to had made a complaint and so couldn't tell us about any feedback received. One patient said that staff would try very hard to sort out any issues that he had so he had never needed to complain.
- St Andrews Healthcare had a complaints policy and staff knew how to handle complaints effectively.
- Staff told us that they received feedback from the outcome of complaints investigations and act on the findings. Feedback was given during reflective practice and at the multidisciplinary team meeting and a lessons learned folder was kept on the ward.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Vision and values

Acute wards for adults of working age and psychiatric intensive care units

Good

- The provider's vision was:

"Transforming lives by building world class mental healthcare services".

Their values were:

Compassion; accountability; respect and excellence.

- We saw posters of these displayed throughout the hospital. Staff were familiar with what these were and told us that they agreed with them and had felt inspired to work for St Andrew's Healthcare because of the vision and values.
- Appraisals and supervisions were up to date and reflected the organisation's visions and values. Staff said that they kept these in mind during their everyday work with patients.
- Staff knew who the most senior manager were within the organisation and told us that they had been to visit the ward following the recent move from Sherwood to Heygate ward.

Good governance

- There were weekly manager and matron meetings to review issues, monthly quality and safety meetings which included the managers, clinicians and compliance manager. There were weekly bed management meetings to review bed numbers.
- Staff received mandatory training and compliance was at 100 %. Staff received supervision and appraisal and compliance rates were 98% for supervision which exceeded the compliance target of 85%. All staff had received an appraisal.
- The ward manager described in detail the process for getting extra staff if the patient mix or range of needs changed or if staff sickness or annual leave required covering. We also saw corresponding paperwork to evidence this process.
- During the inspection we observed staff interacting with patients in the lounge, fitness room and in the outside courtyard.
- Staff participated in clinical audit and all incidents that required reporting were reported.
- Staff learnt from incidents and service user feedback through several different forums.
- Staff followed safeguarding, Mental Health Act and Mental Capacity Act procedures. However, staff were unclear on the use of long term segregation and reviews. The extra care area on the ward was used without adequate paperwork or a framework for recording monitoring or review.
- The ward manager used a dashboard which provided an overview of performance and enabled performance to be monitored.
- The ward manager told us they had sufficient authority and adequate admin support.
- The ward manager had the ability to highlight areas for the risk register which could be added by other trust staff.

Leadership, morale and staff engagement

- The provider supplied data from the 2016 annual staff survey showing that the overall engagement score had increased to 64%. Actions were identified from the results but we were not given any specific data for the unit.
- From the data supplied by the provider staff sickness in the 12 months leading up to inspection was 4.5%.
- The provider had a whistle blowing policy and staff knew where to access this and how to use it if needed. Staff told us that they felt able to raise concerns confidently and without fear of victimisation.
- All of the staff that we spoke with told us that morale had increased greatly since the recent move from Sherwood ward to the newer Heygate ward. Staff told us that there were plans for the new ward that they had been involved in.
- Staff were able to be developed and promoted within teams. There were opportunities for staff to attend a leadership development course and the ward manager had completed this.
- We saw evidence of team working whilst staff de-escalated a situation with a patient.
- Staff were open and transparent with patients and understood Duty of candour. We heard examples of when things had gone wrong and that staff would explain the reasons why to patients and carers.
- Staff were able to complete the annual staff survey in order to give feedback on services. Staff were able to make suggestions at team meetings.

Commitment to quality improvement and innovation

- The service was a member of the National Association of Psychiatric Intensive Care Units. This is a

Acute wards for adults of working age and psychiatric intensive care units

Good

multidisciplinary organisation, which is committed to developing and promoting psychiatric intensive care and low secure services.It aims to improve patient experience and outcome, and to promote staff support and development.

- The ward manager told us that the service had completed research on how much time staff spent with patients.

Inadequate

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Inadequate

Safe and clean environment

- Ward layouts contained some blind spots, and these were not all mitigated by mirrors or the use of closed circuit television. Examples of this included the configuration and opening positions of bedroom doors. However, staff monitored the bedroom corridors and supervised patient access to areas such as the communal gardens and quiet rooms.
- Staff positioned themselves in the bedroom corridors and outside seclusion rooms to monitor patients, particularly overnight. The nursing station was in the middle of each ward, with windows enabling staff to observe the bedroom corridor and main lounge. However, posters and information attached to the windows obscured some lines of sight.
- Each ward had a ligature risk audit. This included points of potential risk identified during the inspection (fittings to which patients intent on self-injury might tie something to harm themselves) such as paper towel dispensers, door frames and cupboard handles, and rated these as low risk. Where applicable the ward had an action plan for changes to be made to further reduce risks. Examples of this included having the paper towel dispensers changed to anti-ligature designs. However, the audits did not contain timescales attached to the action points, therefore at the time of the inspection the risks remained. Staff knew where to locate ligature cutters on each ward, contained in yellow wall mounted boxes.
- Wards had clinic rooms with examination couches and a serving hatch for administering medication to patients. Prichard ward shared their resuscitation equipment with Fairburn ward which is located next door on the same floor of the hospital. During the inspection, we requested provision of the equipment, and timed how long this process took. Staff accessed the bag within one minute and forty five seconds. Staff regularly checked the content of the emergency equipment bag.
- On Fairbairn ward, portable oxygen cylinders held in the clinic room were empty. Staff said they were unable to facilitate safe section 17 leave for a patient without this equipment, so leave was cancelled. Staff did not access a spare cylinder from another ward as an interim measure.
- The fridge temperatures on Robinson ward were monitored. However, on six days, out of 31 in May 2017, there was no record of the fridge temperature. Some diabetes glucose monitoring equipment was out of date. Alert stickers were not placed on medication once in use.
- Medication charts were incomplete and there were gaps in staff signatures. For example, out of eight prescription charts on Prichard ward, there were four omitted doses seen on one patient electronic record for anti-psychotic and a high risk medicine.
- Staff recorded patient allergy information on their medication records. There were systems in place for reporting medication administration errors.
- Each forensic ward contained seclusion rooms. There were two rooms positioned next to each other on Robinson ward. Whilst there was an observation room positioned between the seclusion rooms, staff monitored patients in seclusion on television screens outside the rooms, located on the main access corridor.

The television screens displayed the closed circuit television footage for the seclusion bedroom and bathroom. This impacted on patient dignity, as staff accessing the corridor leading to the seclusion rooms could view the screens and did not adhere to the provider's own seclusion policy in relation to ' maintaining dignity and respect at all times, and in accordance with Code of Practice guidance.' Staff on Robinson ward were unable to operate the two-way intercom to aid communication between staff and a patient in seclusion.

- Ward areas were visibly clean, with furniture in a good condition. However, some patients showed inspectors the condition of their bedrooms. Some bedroom carpets needed replacing, and had walls defaced with offensive language. Patients said they had complained to staff but were unclear of timescales for resolution of these issues.
- We spoke with housekeepers during the inspection. They had product lists for their cleaning trollies to account for all items used on the wards. Housekeeping had locked access to bedrooms during meal times to enable them to clean rooms safely and uninterrupted.
- Bedrooms did not contain alarms to source assistance from staff. Patients told us they would walk onto the bedroom corridor or shout if they needed help. Staff said they completed regular observations of patients, and entered their bedrooms during the night to complete physical checks.
- Where applicable, staff on Fairbairn ward wore vibrating personal alarms to maintain their safety and enable them to respond to incidents and fulfil the requirements of their job role while managing their own hearing impairment.

Safe staffing

- Staff and patients reported concerns about staffing shortages, unfamiliar staff working on the wards and the impact staffing levels had on patient activities and escorted leave.
- Where wards had a full complement of staff at the beginning of a shift, nurse managers reported staff moved to other wards where there were shortages.
- There were 31 permanent staff on Robinson, 8.8 qualified and 22.2 healthcare assistants, 27.4 on Prichard, 10.6 qualified and 16.8 healthcare assistants and 28 on Fairbairn, 9 qualified and 19 healthcare assistants. In the 12 months prior to inspection the vacancy rate ranged from 18% on Prichard to 4% vacancies on Robinson. The turnover rate was 3% on Fairbairn, 6% on Robinson and 29% on Prichard. Between November 2016 and 31 January 2017 there were 1,673 shifts filled by either bank or agency staff and 306 shifts unfilled which equated to 6% of shifts being unfilled. Sickness rates ranged from 1% to 4%.The nurse manager on Fairbairn identified the need to ensure bank and agency staff could communicate with patients on the ward. Sign language interpreters were not included in the core staffing numbers for each shift.
- Nurse managers reported they were able to adjust staffing levels to meet the changing needs of patients requiring high levels of monitoring linked to risks. Requests for additional staff were made in advance if possible, however, when staff were sourced at short notice they could lack familiarity with the ward environment and patient group.
- The ratio of qualified nurses to health care workers for day and night shifts was intended to reflect the needs of the patients, and ensure tasks requiring qualified staff could be safely completed, such as administration of controlled drugs requiring two nurses to authorise. However, qualified nurses identified times where they could only take their breaks on the ward due to being the only nurse on shift, and being unable to leave the ward without cover. When we visited Prichard ward to attend the morning handover meeting, only one qualified nurse covered the night shift. Nurse managers told us the on-site bleep holders relieved staff to allow for breaks, and acted as the second nurse for completion of tasks.
- We observed health care workers monitoring communal ward areas during the day, and when we entered the wards before morning handover, rather than qualified nurses. If the shift consisted of one qualified nurse, and they were with a patient, the remaining staff summoned assistance from each other or from the onsite support team in the event of an emergency.
- Staff reported they placed the needs of patients first, and worked hard to ensure patients had access to one-to-one sessions, activities and escorted leave. However, staff acknowledged that due to staffing pressures this was not always achievable. The provider did not monitor this.
- Staff reported to us there had been multiple bank and locum consultant psychiatrists on the wards since their permanent one left at the start of the year, impacting on

consistency of approach. Doctors covered multiple wards, impacting on out of hours cover and response times for medically reviewing patients in seclusion. Patient records contained ten examples of medical reviews completed by telephone as an interim measure until a doctor reached the ward between 27 December 2016 and 18 April 2017.

- St Andrews had a target for mandatory training compliance of 95%. Data provided prior to the inspection details mandatory training for the men's pathway which includes the forensic wards with completion rates of Management of Actual and Potential Aggression (MAPA) at 56%. MAPA or Prevention and Management of Aggression and Violence (PMAV) at 95%. Safeguarding level 1 at 95%, level 2 at 94% and level 3 at 84%. Immediate life support at 95%. Basic life support at 86%. Infection control at 93%.
- On Robinson ward, staff told us that at the start of each shift senior staff checked the ratio of each management of aggression training type to be clear which staff would take the lead in the event of an incident. There was information to this effect on the wall in the nursing station in the form of a guidance poster. However, staff told us that when they attended emergency response calls on other wards on the hospital site, they would not know this information on entering another ward. We attended shift handover on Prichard ward where staff did not discuss this information, and when questioned, staff reported to feel the techniques were interchangeable. We identified this issue in the June 2016 inspection.
- Some staff identified that their PMAV training was out of date, while awaiting a MAPA training date. The provider had taken the decision to not refresh PMAV training when MAPA training began. Across the whole organisation, 5% of staff had not yet received MAPA training and had not attended PMAV training.

Assessing and managing risk to patients and staff

- On Robinson ward for the six months prior to the inspection there had been seven episodes of seclusion, two episodes of long term segregation, two episodes of restraint, one resulting in use of prone restraint and no use of rapid tranquilisation.
- On Fairbairn ward there had been three episodes of seclusion, no episodes of long term segregation, eight episodes of restraint, four resulting in use of prone restraint and one use of rapid tranquilisation.
- On Prichard ward there had been 10 episodes of seclusion, no episodes of long term segregation, 18 episodes of restraint, nine resulting in use of prone restraint and three episodes of rapid tranquilisation.
- Staff demonstrated awareness of the clinical importance of physical health care monitoring following use of rapid tranquilisation in line with the National Institute for Health and Care Excellence guidance. We found six patients with long term conditions, one on Prichard, one on Robinson, two on Fairbairn and two on Church. However, recording of the completion of physical health care monitoring for patients, particularly those with long term conditions was inconsistent across the wards.
- We found an example of a patient with a long term condition who had not collected their medication in the morning and had not eaten or drunk for approximately 13 hours. Staff had not kept this patient under close observation or adhered to their care plan which contained guidance for staff to follow in the event the patient was non-compliant with their medication. We raised our concerns with the nurse manager, and staff administered the medication with the patient's consent while we remained on the ward.
- During the inspection, there were patients from each ward in seclusion. The terminology used by staff in relation to seclusion, and their understanding of the associated legal framework varied. Patient records showed patients as being in 'long term seclusion' and 'medical seclusion.' Staff were unclear when use of low stimulation rooms moved from de-escalation to seclusion, they told us that this was when a patient became aggressive, rather than at the point the patient was prevented from leaving the room. Staff did not adhere to the provider's seclusion policy or the Mental Health Act Codes of Practice.
- Seclusion care plans recorded the number of staff needing to be present, and the procedures to be followed before opening the seclusion room door for example to give the patient a drink. On more than one occasion we observed these procedures not followed, placing staff at risk of harm. We observed a lack of adherence to procedures by all grades of staff. During the inspection, a staff member sustained injuries while working with a patient in seclusion.
- We found an example of seclusion paperwork not showing clinical decisions for seclusion to cease, or indicating who took professional accountability for that

decision, this was not in line with the provider's seclusion policy. We identified that retrospective entries had been made in a seclusion record by a member of staff who had not been on duty at the time the entry indicated.

- We found examples of patients tampering with wiring in the ward environment, and with personal equipment such as DVD players. Patients shared electrical and battery operated items. Patients dismantled items and removed working parts. Each patient had personal belongings logged on a property inventory, but this did not account for items exchanged on the ward. Staff lacked insight into the reason such items were being exchanged and the associated risks.
- We attended shift handover on Prichard and Robinson wards. During handover staff demonstrated a lack of understanding as to the level of observations each patient should be on, and forgot to provide a handover regarding a patient in seclusion. Inspectors intervened to ensure this information was handed over to the whole team before the shift finished ensuring patient and staff safety.
- From the 13 patient records and care plans reviewed, there was evidence of risk assessments being completed and historic information being collected prior to admission to the ward. However, staff did not update risk assessments following incidents to reflect changes in patient presentation and level of risk. Six out of 21 prescription charts had gaps in the record such as missing signatures.
- Staff used recognised risk assessment tools including short-term assessment of risk and treatability and the historical clinical risk management 20 used to assess risk of violence.
- Safety restrictions were in place on the three forensic wards, including security checks such as counting cutlery and crockery, and having set times for supervised access to hot drinks. Staff confirmed that restrictions linked to patient safety and as a result of incidents for example patients attempting to harm others by throwing hot drinks over them. Where reduction in restrictive practices was feasible to improve quality of life for the patients, such as having increased access to their bedrooms, staff implemented plans to achieve this.
- Staff awareness and understanding of safeguarding practices and procedures varied across the forensic wards. Senior qualified nurses were unclear of procedures to follow, and they would provide guidance to other members of staff. During handover meetings we attended, staff discussed potential safeguarding incidents that occurred during the previous shift; they recorded information on the electronic recording system and, where appropriate, spoke with the patient(s) involved. However, they deferred to the ward social worker and multidisciplinary team for further guidance and to make formal safeguarding referrals. This resulted in clear risk management plans not implemented in a timely way at ward level. Staff identified that where potential safeguarding issues arose over the weekend, they would not be able to consult with the social worker to make a formal safeguarding referral until the start of the working week.
- Prior to the inspection, data provided showed notifications sent to the Care Quality Commission by the provider, for the men's pathway which includes the forensic wards. Total of 205 notifications for the 12 months prior to the inspection. This information did not provide details at a ward level.
- St Andrews had a moving and handling advisor who worked collaboratively with ward occupational therapists and nursing staff to assess for, and provide equipment to aid mobility and transfers for example from bed to wheelchair. Introducing equipment such as walking aids into the ward environment were reportedly discussed within the multidisciplinary team to consider all risk factors for example potential use as a weapon by the allocated patient or others on the ward.
- Where applicable, patients had pressure relieving equipment to maintain skin integrity. The nurse manager on Fairbairn ward identified that staff had completed specialist training in relation to pressure care to meet the needs of patients on the ward and ensure they knew warning signs to monitor for in relation to development of a pressure sore.
- As an adult environment, children and young people did not visit patients on the wards. The hospital had designated child visiting rooms on site.

Track record on safety

- In the 12 months prior to the inspection, Fairbairn ward reported five serious incidents. The nature of these included unauthorised absence, allegations of abuse, disruptive or aggressive behaviour and medical equipment or device disposal incidents.

Inadequate

Forensic inpatient/secure wards

- In the 12 months prior to the inspection Robinson ward reported 12 serious incidents. The nature of these included an accident and an environmental incident. There were five incidents relating to disruptive, aggressive or violent behaviour, and three classified as relating to medication.
- In the 12 months prior to the inspection Prichard ward reported 16 serious incidents. The nature of these included abuse, or allegation of abuse, of a patient by a staff member or third party, and potentially self-inflicted harm. There were three classified as environmental incidents, three unauthorised absence, and five relating to disruptive, aggressive or violent behaviour.
- St Andrews had changed their medication prescribing method from use of paper medication charts to electronic ones. Staff advised this was to improve safety measures linked to administering medication, and reported the design of the new system was to prevent missed authorisation signatures.
- Staff told us they received debriefs and support following incidents or management of difficult situations.

Reporting incidents and learning from when things go wrong

- Most staff demonstrated awareness of how to use the electronic recording system for reporting incidents. From patient records reviewed, where there had been an incident, the records included a reference number from the electronic incident recording system, resulting in an audit trail.
- Nurse managers said that due to staffing pressures, frequency of staff meetings varied across the forensic wards. These meetings were for discussion relating to incidents, dissemination of information for example from investigations, and lessons learnt. To mitigate reduction in staff meetings, nurse managers shared information with staff via email and the use of 'red top alerts' to ensure information was brought to the attention of staff. However, nurse managers and senior qualified nurses were unable to confirm how staff comprehension and implementation of this information was assessed.
- Nurse managers demonstrated a clear understanding of Duty of candour, and the need to ensure openness and transparency, explaining to patients where applicable when things go wrong, with evidence of this seen in ward community meeting minutes. However, some staff reported they were fearful of acknowledging mistakes, and thought their employment status could be at risk as a result.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We examined 13 care and treatment records. Records included completion of assessments on admission, including physical healthcare examinations. However, ongoing physical health care monitoring for patients, particularly those with long term conditions varied across the wards. Four out of the 13 records seen were for patients with long term conditions. Patients told us they accessed GP services in a timely way, and practice nurses were based on site.
- The quality of patient care plans varied across the three wards, with inconsistent levels of multidisciplinary team involvement. From the 13 records reviewed, we were unable to find any record of an up to date care plan for two patients and a further two lacked detail. We found evidence of progress notes, particularly relating to patients in seclusion, copied from one entry to the next, with a standardised format that did not reflect changes in patient presentation or risk.
- Patient progress notes contained sub heading with the aim of providing a holistic review of their treatment. Some contained a repeated phrase 'nothing to report'.
- Most patients told us they met with their named nurse and reviewed their care plans regularly. Some patients reported they did not have a copy of their care plan. From the records examined, staff did not consistently record when they offered the patient a copy of their care plan.
- Patient progress notes, risk assessments, and care plans were on an electronic recording system. Some information such as seclusion records were completed on paper forms. The ward administrator scanned this information onto the electronic system; there could be a delay in adding this information to the system.

- Nurse managers reported that members of the multidisciplinary team completed pre admission assessments. There were case examples given where the team had completed an assessment and determined that the patient did not meet their eligibility criteria or was unsuitable for the setting. The senior management team reportedly overrode this decision at times. Staff expressed frustration that the team's clinical judgement was undermined. They also raised concerns about the lack of consideration given to the needs and dynamics of the existing patients on the ward.

Best practice in treatment and care

- From the 21 medication records examined, there was evidence that staff adhered to National Institute for Health and Care Excellence guidance when prescribing medication. Where applicable, records demonstrated completion of the Glasgow Antipsychotic Side-effect Scale. Some patients told us they had discussed their concerns regarding medication and side effects with the multidisciplinary care teams during ward rounds and care review meetings.
- Patients accessed psychological therapies in line with National Institute for Health and Care Excellence guidance; these included cognitive behavioural therapy, dialectical behavioural therapy, and sex offender treatment programmes. Treatment plans and approaches were adapted to meet the needs of patients on Fairbairn ward with hearing impairment. There was reference made to National Institute for Health and Care Excellence guidelines for those patients with positive behaviour support care plans.
- We attended the shift handover meeting for Prichard ward where staff discussed patient food and fluid intake during the previous shift. However, we found an example of where a patient had not eaten for approximately 13 hours, and their associated medical conditions meant they needed to eat and drink regularly. Staff did not adhere to the guidance in their care plan in the event this happened and did not encourage the patient to eat, for example, by giving them snacks in their bedrooms as an interim measure. Care Quality Commission staff notified staff who administered the medication with the patient's consent while we remained on the ward.
- Patient records contained use of Health of the Nation Outcome Scales – Secure, to enable staff to assess and record severity outcomes for patients.
- Staff were unable to tell us about their involvement in clinical audits completed on the wards. Nurse managers told us medication; clinical notes, supervision records, daily environmental and external checks, cleanliness, and food quality were among the areas included on the audit calendar. We saw examples of the completed medicines and ligature risk audits. Completion of the ligature risk audits was by members of the provider's safety team, rather than by ward based clinicians. The quality of the action plan and understanding of clinical risks reflected in all three ligature risk audits demonstrated the need for greater oversight by ward based clinicians. The action plans did not contain timescales for completion; therefore risks identified for example in November 2016 remained during our inspection visit.

Skilled staff to deliver care

- All forensic wards had a full range of mental health disciplines within their multidisciplinary teams. These included occupational therapists, social workers, and psychologists working collaboratively with the doctors and nurses on the wards.
- Staff told us they received a thorough induction, and shadowing opportunities. Health care workers received training in line with the national care certificate standards.
- Due to staffing pressures, and one of the nurse managers being responsible for one forensic and two rehabilitation wards, staff told us that supervision was infrequent. However, staff acknowledged that nurse managers had an open door policy, therefore access to informal guidance and advice was available. Staff were referring to clinical and managerial supervision interchangeably. St Andrews had a clinical supervision target of 85% compliance rate. From data provided supervision rates on Robinson ward were 88%, Fairbairn ward 92% and on Prichard ward were 94% in the 12 months prior to the inspection. However, the data provided indicated that compliance rates were not consistent, with Fairbairn ward achieving 56% in December 2016 and Robinson ward achieving 59% in August 2016.
- When we met with the qualified nurse at Prichard ward handover, they had been the only nurse on that night

shift. We were given assurance from the provider that the four night site co-ordinators regularly cover breaks for wards with one qualified on duty and they provide clinical advice when needed.

- Many of the qualified nurses on day and night shifts were newly qualified or had been practicing for approximately a year. Whilst they reported they felt supported, they recognised their level of skills and clinical experience was limited.
- Each ward produced a performance indicator dashboard for each month. This contained clinical supervision rates and broke numbers down into completion rates for qualified nurses and health care workers. For April 2017 Robinson ward supervision rates for qualified nurses was 83% and for health care workers was 76%. For Fairbairn ward supervision rates for qualified nurses was 88% and for health care workers was 88%, and for Prichard ward supervision rates for qualified nurses was 94% and for health care workers 88% for the same period. Staff on Prichard ward had access to regular reflective practice sessions.
- Staff told us they could choose who they received supervision from. The provider's supervision policy confirmed that 'supervisees should choose their supervisors'. The provider had policies for dealing with poor performance when identified, and for managing absences and sickness. However, there was no formal line management structure to provide staff with regular one to one meetings to discuss wellbeing, training needs and performance.
- Appraisal completion rates for qualified nurses and health care workers were between 90 and 97% for all three wards. Nurse managers advised that staff only received managerial supervision twice a year, linked to the appraisal process. Revalidation for doctors on all three wards was 100%.
- From data provided, all three wards had staff who were suspended or under supervision in the 12 months prior to the inspection. Nurse managers advised they had no staff suspended or under supervision at the time of the inspection visit.

Multi-disciplinary and inter-agency team work

- The wards held regular multidisciplinary team meetings. We observed the meeting on Robinson ward. The meeting offered staff the opportunity to discuss clinical cases and review incidents. Patients had the opportunity to raise and ask questions either face to face by attending a portion of the meeting or through a feedback system in place on the wards. Staff supported patients to complete a feedback form if they were unable to do so independently.
- We attended shift handover meetings on Prichard and Robinson wards. On Prichard ward the night staff completed an electronic handover sheet, which they printed and used as a source of reference in the handover. Staff could access the printed sheet throughout the next shift held in a folder in the nursing station. Qualified nurses took notes, and allocated tasks within the team. However, at the start of the meeting there were six members of staff and by the end of the meeting there were ten. Those staff who missed information did not receive a summary, it was therefore unclear how these staff members were aware of all information discussed, as the sheet held in the handover folder had limited information on it, and did not reflect inter-staff discussions during the meeting. Staff did not discuss observation levels for each patient during the handover. The reason given for staff being late to the meeting was the time taken passing through the security reception to get onto the ward.
- On Robinson ward staff did not complete an electronic handover sheet, instead using pieces of paper to write on. Staff forgot to provide a handover regarding a patient in seclusion. Inspectors intervened to ensure this information was given to the whole team before the shift finished ensuring patient and staff safety. Staff for day and night shifts appeared unclear what observation levels patients were on, in relation to risks.
- Nurse managers identified the challenges involved with maintaining working relationships with community mental health services with many patients placed from out of county. Patients expressed frustration in relation to the time taken for feedback on decisions and communicated back to the ward by external organisations such as the Ministry of Justice.

Adherence to the MHA and the MHA Code of Practice

- St Andrews had a target for mandatory training compliance of 95%, with attention reportedly given to wards where compliance was 90% or below. Data provided, prior to the inspection, detailed mandatory training for the men's pathway, which included the forensic wards, with completion rates for Mental Health Act training at 89%.

Inadequate

Forensic inpatient/secure wards

- Mental Health Act paperwork was scrutinised and scanned onto the provider's electronic records system by the Mental Health Act administration team. T2 and T3 paperwork in relation to consent to treatment was linked to patient medication records. Paperwork was in order for the records we reviewed.
- Patient leave entitlement was clearly documented in their records and outcomes from leave placed in progress notes. Patients used multidisciplinary meetings and community meetings to make requests for their leave entitlement to be reviewed or as a forum to make suggestions in relation to activities they wanted to participate in.
- Activity coordinators and occupational therapists worked closely with patients, designing weekly activity programmes, with leave entitlement factored into the plans. Where a patient did not have grounds leave or authorisation to go out of the hospital building, staff tailored programmes to maximise involvement in meaningful activity whilst adhering to the terms of their detention.
- From the 13 patient records examined, all contained a document to indicate that patient's had their rights under the Mental Health Act explained to them, and reviewed every six months, with a reminder setting in place on the electronic records system.
- Patients had access to advocacy and independent mental health advocates based on the hospital site for support with complaints and tribunals. Information leaflets on services including advocacy were on display in ward areas. Patients on Fairbairn ward could access independent interpreters who worked alongside the advocacy service.
- Patients on Fairbairn ward accessed information DVDs and posters explaining their rights under each section of the Mental Health Act.
- Nurse managers told us that the Mental Health Act administration team completed audits of Mental Health Act paperwork.

Good practice in applying the MCA

- St Andrews had a target for mandatory training compliance of 95%. Data provided, prior to the inspection, detailed mandatory training for the men's pathway, which included the forensic wards, with completion rates for Mental Capacity Act training at 82%.
- For the five months prior to the inspection, up to the 31 January 2017, there had been no Deprivation of Liberty Safeguards applications or authorisations for the three forensic wards. We sourced verification on this during the inspection. All the patients on the forensic wards were detained under the Mental Health Act.
- Nurse managers on Robinson and Prichard wards did not identify any patients assessed to lack mental capacity to make decisions in relation to their care and treatment. On Fairbairn ward more specialist assessments were completed, tailored to the needs of patients with hearing impairment and gaps in their formal education.

Are forensic inpatient/secure wards caring?

Good

Following our inspection in June 2016, we rated this service as good for caring. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.

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

(for example, to feedback?)

Good

Following our inspection in June 2016, we rated this service as good for responsive. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.

Are forensic inpatient/secure wards well-led?

Inadequate

Vision and values

- The provider's vision was

Inadequate

Forensic inpatient/secure wards

"Transforming lives by building world class mental healthcare services".

- Their values were:

Compassion; accountability; respect and excellence.

- Staff knowledge of the provider's vision and values varied across the wards and level of time they had been in post.
- Staff knew the most senior managers in the organisation, and spoke positively about the support received from the modern matron and director of nursing. Staff reported a sense of disconnect between executive and board level employees, and the wards.

Good governance

- The delivery of high quality care was not assured by the leadership, governance, or culture in place. The monitoring and governance processes were not operationally effective to ensure issues were picked up in a timely manner. We identified a lack of effective monitoring and awareness of poor cleanliness and environment issues. A lack of effective monitoring of record keeping standards particularly in relation to seclusion and long term segregation. We found equipment which had passed its expiry date or safety testing date. There was a lack of operationally effective risk management processes in relation to ligature points and individual patient risks.
- Staff received mandatory training in relation to the Mental Health Act, Mental Capacity Act and safeguarding. The area of concern identified related to the level of staff yet to complete Management of Actual and Potential Aggression (MAPA) training at 56%. With approximately 44% of the total workforce for the male pathway having not completed MAPA training, each shift consisted of some staff using MAPA techniques and some Prevention and Management of Aggression and Violence (PMAV). The provider explained in the presentation at the start of the inspection that all staff on the Northampton site would be MAPA trained by March 2018. We could not source assurances at a ward level of operationally effective, interim measures used to manage the risks associated with having staff trained into two different techniques. This issue had been identified in the June 2016 inspection.
- Nurse managers did not hold a record of training data for their staff, as the provider held this information centrally. Whilst nurse managers explained they received a reminder when training was due for renewal, they did not have ward level information to use for monitoring staff competency and performance.
- Staff told us supervision was infrequent, with support offered in group rather than one to one sessions. Nurse managers said staff had managerial supervision twice a year, linked to the appraisal process. It was unclear how managers monitored individual performance and professional development effectively. The inspection team identified a lack of individual supervision reflected in clinical judgements made on the ward in relation to areas such as quality of documentation, risk management and seclusion practices.
- We reviewed the last three months staffing rosters, staffing numbers per shift on the whole were achieved. However, the skill mix and level of qualified nurses was an area of concern. We identified qualified nurses on each ward who were working as the only nurse on a shift, or were acting up into senior roles due to sickness and absence on the wards. These nurses had been qualified for approximately a year. Whilst these staff reported they felt well supported, their level of clinical expertise and judgement was limited due to a lack of experience and at times, a lack of managerial oversight.
- Each ward had a level of administration cover. Administrators supported staff with tasks such as scanning documents onto the electronic recording system, therefore enabling staff to spend more time with patients.
- Robinson ward had introduced a communications nurse who attended shift handovers, and coordinated tasks such as security passes for visitors, liaising with family to make arrangements for patient leave and supporting patients with accessing their finances. This was a pilot scheme on the ward with the aim of reducing the amount of time staff on shift spent completing these tasks, as it was identified this removed them from the ward and reduced time with patients. Initial feedback was positive in relation to the impact this role had on the rest of the staff team, it was unclear if this role would develop further or extend onto the other forensic wards.
- Due to staffing pressures, frequency of staff meetings varied across the forensic wards. This would be the forum along with clinical supervision for discussion relating to incidents, dissemination of information for example from complaint investigations, and sharing lessons learnt.

Inadequate

Forensic inpatient/secure wards

- For the 12 months prior to the inspection, Robinson ward received three complaints, one was upheld, and none referred to the ombudsman. The nature of complaint received, included, a patient complaining their leave was cancelled due to staffing shortages.
- Prichard ward received four complaints, one upheld and none referred to the ombudsman. The nature of complaint received, included theft of patient property.
- Fairbairn ward had received no complaints for the same reporting period.
- Staff knowledge of safeguarding practices and procedures varied across the wards with a tendency to defer to the ward social worker rather than taking a lead role in the process.
- Nurse managers were unclear of ward and individual key performance indicators used by St Andrews to gauge practice standards on the wards. Each ward produced a monthly performance indicator dashboard, these were displayed in the nursing stations, but it was unclear if staff understood the content, or if the documents were discussed with staff.
- Nurse managers told us they did not submit items to the provider risk register.

Leadership, morale and staff engagement

- St Andrews 2016 staff survey achieved an employee engagement score of 64%, with 86% of staff saying “at St Andrew’s we look after our patients/service users with compassion”. The survey identified areas of improvement including: “leadership communication, the need for clear communication of the vision and goals and how these relate to the local pathway or function. The need for leadership or empowerment, staff feeling comfortable about having their say, doing the right thing, ensuring there is an environment for empowerment”.
- Robinson ward reported a 3% staff sickness rate. Prichard ward reported 4% and Fairbairn ward 1% for the 12 months prior to the inspection. Nurse managers on Fairbairn and Robinson wards identified staff on sick leave at the time of the inspection who sustained work based injuries. Nurse managers demonstrated awareness of the procedures in place to support staff returning to work, and acknowledged the importance of working collaboratively with human resources and occupational health departments.
- Staff told us they knew how to implement the provider whistleblowing process, and there was a confidential hotline staff could access. Some staff said they feared victimisation or reprisals if they raised concerns, particularly to the senior management team. The wards did not have any bullying and harassment cases under investigation.
- Nurse managers identified staff morale to be low.
- Prichard ward reported to have 39% turnover of staff in the 12 months prior to the inspection. Fairbairn ward reported 3% turnover and Robinson ward 6% for the same reporting period.
- Staff recognised the value of strong working relationships with their colleagues and the importance of team work. Staff respected nurse managers and confirmed there was an open door policy for accessing support.
- Nurse managers demonstrated a clear understanding of Duty of candour, and the need to ensure openness and transparency, explaining to patients where applicable when things go wrong, with evidence of this seen in records. However, some staff reported they were fearful of acknowledging mistakes, and thought their employment status could be at risk as a result.
- We identified areas of clinical practice where greater management oversight and leadership was required. This was particularly apparent in relation to ward cultures around seclusion practices, and standards of documentation.

Commitment to quality improvement and innovation

- Occupational therapists working within the forensic, male pathway worked to the Model of Creative Ability accreditation framework.
- Fairbairn ward displayed information pictorially and had DVDs explaining patient rights under each section of the Mental Health Act. Staff used images with patients to de-escalate situations or to explain processes and timescales. Examples of this included patient journeys from admission to discharge with pictorial information to aid understanding of the process and tasks the patient needed to complete in preparation for discharge.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Inadequate

Safe and clean environment

- The rehabilitation wards contained blind spots impacting on lines of sight for staff to monitor patients. Ferguson ward, due to the shape and configuration of the bedroom corridor with doors opening outwards, had reduced lines of sight. There were mirrors in place to mitigate some of the risks. We identified that due to the condition of the joints on the main convex mirror it did not cover some angles of the ward. However, staff positioned themselves on the bedroom corridors and in communal areas to monitor patient movement. Some patients were under one to one observation, with staff seated outside bedrooms.
- Each rehabilitation ward had a ligature risk audit, but many risks identified during the inspection were not included in the audits or linked to patient care plans to adequately mitigate the risks. Some ward areas on the risk audits were recorded as not accessed by patients, for example the corridor on Ferguson ward that contained staff offices, yet this was the only route for patients to access the roof top garden. The quality of the action plans and understanding of clinical risks reflected in all three ligature risk audits demonstrated the need for greater oversight by nurse managers and senior clinicians. The action plans did not contain timescales for completion; therefore risks identified, for example, in June 2016 remained during our inspection visit. The ligature risk audit lacked detail, with items such as the safes for the storage of valuables in patient bedrooms on Ferguson ward not listed on the audit.
- The ligature risk audit for Fenwick ward contained an action plan. This indicated staff would receive a copy of the action log to make staff aware of the ligature points identified, to enable staff to manage environmental risks linked to individual patients. This action requirement was marked as high priority. Staff told us they had not received this information.
- Staff knew where to locate ligature cutters on each ward, contained in yellow wall mounted boxes.
- Wards had clinic rooms with examination couches and a serving hatch for administering medication to patients. Church and Fenwick wards shared their resuscitation equipment with another ward in the same hospital building. Staff regularly checked the content of the emergency equipment bag, using a pictorial check list.
- Ferguson ward clinic room had a nebuliser with nine month out of date electrical safety testing.
- The clinic room on Fenwick ward contained some out of date medication and some out of date equipment including respiratory masks. They had two sharps disposal bins without signatures to indicate when and who assembled them. One of the cupboards was brown with dirt on the inside. We notified the nurse in charge of the ward of these concerns.
- Church ward had two sharps disposal bins without signatures to indicate when opened.
- Each rehabilitation ward contained a seclusion room. The room on Church ward was in use at the time of the inspection, so only viewed from outside to prevent distress to the patient. This patient was from another ward. They had staff from the other ward overseeing

patient care, but staff on Church ward responded to incidents when personal alarms were activated. We observed staff responding to incidents during our time on the ward. We met with the nurse manager who told us the patient was moving to a more suitable ward setting later the same day due to the impact their care and support needs had on patients on Church ward. The nurse manager said Church ward staff were unable to provide the usual level of activities on the ward as staff were covering breaks and offering support to meet the needs of the patient in seclusion.

- Fenwick ward had a seclusion room, and an extra care suite positioned in a corridor accessible via the main ward bedroom corridor. Closed circuit television monitors of the seclusion room bedroom and bathroom gave a full view of the toilet. The monitors were positioned on the wall outside the seclusion room. With the door from the bedroom corridor open or when a patient accessed the extra care suite, patients and staff could view the monitors. This impacted on patient privacy and dignity and did not adhere to the provider's seclusion policy of guidance from the Mental Health Act Codes of Practice.
- Staff on Fenwick ward could not operate equipment in the seclusion room or the extra care suite such as the intercom and blinds. The seclusion room bathroom did not contain a shower, and staff appeared unfamiliar with the environment.
- Staff on Fenwick ward could not operate the equipment in the extra care suite. The lounge room contained a television with battery operated hand controls. The controls were on the surface next to the television ready for use. When asked, staff told us such items would always be locked away to prevent access by a patient wishing to use for purposes of harm, but the items were accessible and left on the surface when we exited the extra care suite.
- Patients were encouraged on Fenwick ward to access clean laundry to change their beds and complete independent living tasks as part of their rehabilitation programme. However, we noted the laundry stored on the ward was in large clear plastic bags that did not appear to contain holes. Staff assured us they removed all plastic before giving items to patients.
- The seclusion room on Ferguson ward was visibly dirty, with a very stained toilet bowl. The door to the seclusion bedroom opened outwards onto the main ward bedroom corridor. Staff told us, that to provide a patient in seclusion with food they were unable to enter the bedroom until they locked the patient in the seclusion room bathroom. The two way intercom and blind for the seclusion bedroom did not work. Closed circuit television screens positioned in the adjacent staff observation room displayed footage for the seclusion bedroom and bathroom and gave a full view of the toilet. This impacted on patient dignity. Staff provided us with a copy of the maintenance log to confirm they had reported the issues with the two way intercom and blind.
- Ferguson ward was visibly very unclean. Surfaces including handrails had thick coatings of dust and dirt on them. Toilets were blocked with effluence back flowing into the toilet bowl. Shower rooms smelt strongly of drains. Some bedroom walls contained exposed plaster, and sealed flooring was detached from the walls and contained dirt. The housekeeping cupboard contained used mops, left in buckets containing dirty water. Staff were not adhering to infection control practices on this ward for the safe care and treatment of patients. We escalated our concerns regarding the condition of the ward to the attention of the nurse manager and housekeeping team. Assurances were given that staff would start a deep clean of the whole ward later that day. The environmental condition of Ferguson ward did not reflect completion of regular cleanliness and housekeeping audits.
- Hand sanitiser gel dispensers on the ground floor entrance to Ferguson ward were empty on two consecutive times when the inspection team visited the ward.
- Ferguson ward therapy kitchen fridge contained food items with use by stickers attached. The dates recorded were incorrect and did not adhere to guidance provided by the food manufacturer. We escalated our concerns to the attention of the nurse manager to address.
- Ferguson ward bathrooms and communal seating areas were extremely hot, and patients presented as fatigued.
- Staff on Ferguson ward were unable to provide personal alarms for the four members of the inspection team. Those provided appeared in need of replacement. We tested one of the alarms to check this was working, before entering the main ward environment to ensure the safety of our team. The alarm was working, but it was in a poor condition.

- Church and Fenwick ward bedrooms, bathrooms and communal areas were visibly clean. However, ensuite and communal bathrooms on Church ward smelt very strongly of drains making it unpleasant for patients to use.
- The television in the communal lounge on Church ward was broken and had been for approximately two weeks. Staff told us a replacement was on order.
- We visited Ferguson ward during the follow up, unannounced inspection. The visible cleanliness of the seclusion room bedroom and bathroom had improved. However, the blind remained broken. A new control for the intercom was installed in the staff observation room, but this was not connected to the button in the bedroom, therefore the intercom remained out of use.
- Some of the toilets on Ferguson ward were out of order during the follow up visit. The toilets that remained in use were flushing properly, however shower rooms continued to smell of drains. The overall temperature on the ward was cooler, and patients appeared more active.
- Staff had redecorated the bedroom with exposed plaster on the walls. However the sealed flooring remained detached from the walls in communal areas impacting on infection control standards.
- The condition of the housekeeping cupboard had improved. However, it still contained visibly dirty mop heads with a coating of dirt on the floor. The hand sanitiser gel dispenser on the entrance to the ward contained gel.
- We examined the content of the therapy kitchen fridge. This contained one out of date item, we brought this to the attention of the staff member present.
- Staff did not offer the inspection team personal alarms while on Ferguson ward.
- Staff knowledge of infection control practices on Ferguson ward remained of concern. Staff struggled to source key information relating to patient care and treatment by healthcare professionals involved in their wound care on their electronic recording system. We questioned how staff disseminated information regarding infection control and associated risk management to staff, particularly those unfamiliar with the ward. Staff initially told us they shared this information in handover meetings, and that paper copies of each handover meeting were held in a folder. We examined the content of the handover notes folder, this did not contain up to date records. Staff wore nail varnish, jewellery and long sleeved clothing, preventing them being bare below the elbow in line with best practice for infection prevention and control.

Safe staffing

- Staff, patients, family members and carers reported concerns about staffing shortages, unfamiliar staff working on the wards and the impact staffing levels had on patient activities and authorised leave.
- Where wards had a full complement of staff at the beginning of a shift, nurse managers reported staff moved to other wards where there were shortages. We overheard ward staff receiving telephone calls at the start of shifts to see if they had staff available to move to other wards.
- Ferguson ward had 24.4 permanent staff, Church and Fenwick wards had 26 permanent staff. The vacancy rate ranged from 2% on Ferguson to 3% on Church and Fenwick. Sickness rates ranged from 6% on Ferguson to 4% on Church and Fenwick. In the 12 months prior to inspection there was a high turnover rate of staff on Ferguson with 20% with Church and Fenwick having 4%. Between November 2016 and 31 January 2017, there were 450 shifts filled by bank or agency staff, and 83 shifts (15%) were not filled to cover absence. Nurse managers adjusted staffing levels to meet the changing needs of patients requiring high levels of monitoring linked to risks. Requests for additional staff were made on the day rather than in advance of each shift resulting in staff sourced lacking familiarity with the ward environment and patient group.
- The ratio of qualified nurses to health care workers for day and night shifts was intended to reflect the needs of the patients, and ensure safe completion of tasks requiring qualified staff, such as administration of controlled drugs requiring two nurses to authorise. However, qualified nurses identified times where they took breaks on the ward due to being the only nurse on shift, and being unable to leave the ward without cover. Nurse managers told us the on-site bleep holders relieved staff to allow for breaks, and acted as the second nurse for completion of tasks.
- When we visited Church ward to attend the morning handover meeting, there had been no qualified nurse on the night shift. Instead, three health care assistants ran the shift. One of the health care assistants gave morning handover. The qualified nurse that started on

the day shift did not receive any form of handover from a qualified nurse. Staff told us the only time a qualified nurse had been on the ward during that night shift was to administer medication.

- We observed healthcare assistants monitoring communal ward areas, rather than qualified nurses during the day and when we entered the wards before morning handover. If the shift consisted of one qualified nurse, and they were with a patient, the remaining staff summoned assistance from each other or from the onsite support team that consisted of staff from each ward responding to requests for assistance in the hospital in the event of an emergency.
- Staff reported to place the needs of patients first, and worked hard to ensure patients had access to one-to-one sessions, activities and escorted leave. However, staff acknowledged that due to staffing pressures this was not always achievable. Patient records examined recorded multiple entries of leave cancellation due to staffing shortages. We observed patients turned away from the nursing station or told they could not have leave without provision of an explanation.
- Staff told us there was adequate medical cover during the day and overnight, and that doctors attended the ward in the event of an emergency or where patients required medical review while in seclusion.
- St Andrews had a target for mandatory training compliance of 95%, with attention reportedly given to wards where compliance was 90% or below. Data provided prior to the inspection details mandatory training for the men's pathway which includes the rehabilitation wards with completion rates of Management of Actual and Potential Aggression (MAPA) at 56%. MAPA or Prevention and Management of Aggression and Violence (PMAV) at 96%. Safeguarding level 1 at 95%, level 2 at 94% and level 3 at 84%. Immediate life support at 95%. Basic life support at 86%. Infection control at 93%.
- As 44% of the total workforce for the male pathway had not completed MAPA training, each shift consisted of some staff using MAPA techniques and some PMAV.
- Some staff identified that their PMAV training was out of date, while awaiting a MAPA training date. Across the whole organisation, 5% of staff did not have MAPA or up to date PMAV training.

Assessing and managing risk to patients and staff

- For the six months prior to the inspection Ferguson ward reported six episodes of seclusion, two episodes of long term segregation, four episodes of restraint, one resulting in use of prone restraint and one use of rapid tranquilisation. Church and Fenwick wards for the six months prior to the inspection reported six episodes of seclusion, one episodes of long term segregation, four episodes of restraint, two resulting in use of prone restraint and two use of rapid tranquilisation.
- Staff demonstrated awareness of the clinical importance of physical health care monitoring following use of rapid tranquilisation in line with the National Institute for Health and Care Excellence guidance. However, recording of the completion of physical health care monitoring for patients, was inconsistent across the wards.
- We found an example of where a patient required specialist wound care, and adherence to specific infection control procedures. Staff did not appear to recognise the importance of these treatment practices, and staff did not follow the patient's care plan and risk assessment. We escalated our findings to the provider's modern matron as we could not source robust assurances from the ward team about the care and treatment of this patient, and the potential risks posed to others on the ward. Records for this patient contained guidelines for the patient to follow in relation to the care of their wound. Noncompliance by the patient was linked to cancellation of leave, with staff taking a potentially punitive approach to the patient's care and treatment.
- From the eight medication records examined on Fenwick ward, two patients were effectively managing their medication administration independently, as part of their rehabilitation programme.
- Staff recorded patient allergy information on their medication records. There were systems in place for reporting mediation administration errors.
- From the 14 patient care and treatment records reviewed, there was evidence of risk assessment completion and historic information collected prior to admission to the ward. However, staff did not update risk assessments following incidents. Staff on Fenwick ward lacked understanding as to the importance of this, and the need to update external organisations involved with the patient's care such as the Ministry of Justice. Staff did not review or increase patient observation levels following incidents to manage potential risks to

other patients and staff. Where risk incidents involved staff members, senior staff and clinicians did not recognise the need to complete timely internal investigations.

- Staff used recognised risk assessment tools including Short-Term Assessment of Risk and Treatability and The Historical Clinical Risk Management used to assess risk of violence.
- Blanket restrictions were in place on the three rehabilitation wards, including security checks such as counting cutlery and crockery, and having set times for supervised access to hot drinks, and internet access ceasing at 6pm. Restrictions were not linked to individualised risk assessments.
- Staff awareness and understanding of safeguarding practices and procedures varied across the rehabilitation wards.
- Staff completed searches of patients and their property when returning from leave away from the ward. We observed staff on Ferguson ward complete a search of a patient, at the entrance to the ward in full view of peers seated in the communal lounge. This impacted on privacy and dignity for that patient. We alerted the nurse manager to our concerns. The need for searches had not been individually assessed.
- We identified an incident relating to contraband items brought onto Fenwick ward by a patient, and stored in their bedroom. Staff had not identified these items during searches of patient and property completed prior to re-entering the ward environment.
- Staff on Church and Fenwick wards lacked insight into work related risks and professional boundaries. We observed staff seated on the floor and on the arms of chairs with patients participating in the ward community meetings. Staff did not recognise the risks associated with sitting on the floor in relation to ease of responding to incidents, and the potential to sustain injury. We observed patients invading the personal space of staff, and staff not reminding patients of acceptable boundaries and behaviours.
- As an adult environment, children and young people did not visit patients on the wards. The hospital had designated child visiting rooms on site.

Track record on safety

- In the 12 months prior to the inspection, Ferguson ward reported five serious incidents. The nature of these all related to unauthorised absence.
- In the 12 months prior to the inspection Church and Fenwick wards reported nine serious incidents. The nature of these included four allegations of abuse of patients by staff. All allegations were investigated. The provider took appropriate action.
- We identified a high risk incident that would meet the criteria for investigation as a serious incident on Fenwick ward. A patient had obtained access to the internet when it was against the condition imposed by the Ministry of Justice. Staff had not notified the Ministry of Justice, commissioners or Care Quality Commission in relation to this incident. CQC staff brought this to the attention of the consultant to ensure immediate notification to the Ministry of Justice while we remained on the ward.
- St Andrews had changed their medication prescribing method from use of paper medication charts to electronic ones. Staff advised this was to improve safety measures linked to administering medication, and reported the design of the new system was to prevent missed authorisation signatures.
- Staff told us they received debriefs and support following incidents or management of difficult situations.
- Data provided prior to the inspection details notifications sent to Care Quality Commission by the provider, for the men's pathway which includes the rehabilitation wards. Total of 205 notifications for the 12 months prior to the inspection. This information did not provide details at a ward level.

Reporting incidents and learning from when things go wrong

- Most staff demonstrated awareness of how to use the electronic recording system for reporting incidents. From patient records reviewed, where there had been an incident most records included a reference number from the electronic incident recording system, resulting in an audit trail. Patient records on Fenwick ward contained reference numbers to reflect incident recording. However, once reported no further steps were taken to safeguard staff and patients from further risk of harm.
- Nurse managers said that due to staffing pressures, frequency of staff meetings varied across the

Long stay/rehabilitation mental health wards for working age adults

Inadequate

rehabilitation wards. These meetings, along with clinical supervision, were for discussion relating to incidents, dissemination of information for example from investigations, and lessons learnt. To mitigate reduction in staff meetings, nurse managers shared information with staff via email, and the use of 'red top alerts' to ensure information was brought to the attention of staff. However, nurse managers and senior qualified nurses were unable to confirm assessment of staff comprehension and implementation of this information.

- Nurse managers demonstrated some understanding of Duty of candour, and the need to ensure openness and transparency, explaining to patients where applicable when things go wrong. We observed patients asking to go on grounds leave, staff told patients this was not possible but did not provide them with an explanation or offer an alternative time.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We examined 14 care and treatment records. Records included completion of assessments on admission, including physical healthcare examinations. Two out of the 14 records looked at were for patients with long term conditions. However, ongoing physical health care monitoring for patients, particularly those with long term conditions varied across the wards. Patients told us they accessed GP services in a timely way, and practice nurses based on site. We identified an example of staff not adhering to wound care and infection control guidance linked to the patient's care and treatment plan.
- The quality of patient care plans varied across the three wards, with inconsistent levels of multidisciplinary team involvement.
- We identified four patients with no up to date care plan, and two with very limited information not linked to their risk assessment from the 14 care and treatment records examined.
- Patients on Fenwick ward did not attend all sessions on their therapy treatment programme. We observed staff struggling to engage with patients, who wished to remain in bed rather than attend morning sessions. Night staff did not prompt patients to start preparing for the day prior to the therapy team entering the ward. This impacted on levels of meaningful activity and rehabilitation completed on the ward.
- Patient progress notes contained sub heading with the aim of providing a holistic review of their treatment. However, some contained repeated phrases like 'nothing to report,' 'no risks identified', even where we identified significant, ongoing risks in the patient's records.
- Most patients told us they met with their named nurse and reviewed their care plans regularly. Some patients reported they did not have a copy of their care plan. From the records examined, staff did not consistently record when they offered the patient a copy of their care plan. Patient progress notes, risk assessments and care plans were on an electronic recording system.
- Staff confirmed that whilst members of the multidisciplinary team completed pre admission assessments, many of the patients on the rehabilitation wards had moved through the male care pathway at St Andrews from medium secure wards. Staff therefore reported familiarity with these patients, and did not recognise the potential for patient risks changing in relation to differences in security levels in the different environments.

Best practice in treatment and care

- Staff supported patients in managing their mental illness and to work towards transition into community services. This approach included engaging in community based activities including education, voluntary or paid work, attending training and learning activities. Arts and Crafts and Workbridge provided the opportunity to learn and develop work and life skills through a range of activities including ceramics, horticulture, woodwork, catering, and design and printing.
- From the 23 medication records examined, there was evidence that staff adhered to National Institute for Health and Care Excellence guidance when prescribing medication. Where applicable, records demonstrated completion of the Glasgow Antipsychotic Side-effect

Scale. Some patients told us they had discussed their concerns regarding medication and side effects with the multidisciplinary care teams during ward rounds and care review meetings.

- Patients accessed psychological therapies in line with National Institute for Health and Care Excellence guidance; these included cognitive behavioural therapy, dialectical behavioural therapy and sex offender treatment programmes. There was reference made to National Institute for Health and Care Excellence guidelines for those patients with positive behaviour support care plans. Clinical psychologists facilitated reflective practice sessions with the team to develop psychological formulations which support therapeutic rapport and optimism.
- Patient records contained use of Health of the Nation Outcome Scales – Secure, to enable staff to assess severity and outcomes and rate clinical risks.
- Staff were unable to tell us about their involvement in clinical audits completed on the wards. Nurse managers told us medication; clinical notes, supervision records, daily environmental and external checks, cleanliness, and food quality were among the areas included on the audit calendar. The cleanliness checks did not pick up the issues we identified on inspection so we were not assured the audit process was effective.

Skilled staff to deliver care

- All rehabilitation wards had a full range of mental health disciplines within their multidisciplinary teams. These included occupational therapists, social workers and psychologists working collaboratively with the doctors and nurses on the wards.
- Some of the qualified nurses on day and night shifts were newly qualified or had been practicing for approximately a year. Whilst they reported to feel supported, their level of skills and clinical experience was limited.
- Staff told us they received a thorough induction, and shadowing opportunities. Health care workers received training in line with the national care certificate standards.
- Due to staffing pressures and the nurse managers being responsible for multiple wards within the male care pathway, staff told us that supervision was infrequent. However, staff acknowledged that nurse managers had an open door policy, therefore access to informal guidance and advice was available.
- St Andrews has a clinical supervision target of 85% compliance rate. From data provided supervision rates on Ferguson ward were 97%, Church and Fenwick wards 96% for the 12 months prior to the inspection.
- Staff told us they could choose who they received supervision from. This was in line with the provider's supervision policy that indicated that 'supervisees should choose their supervisors.' It was unclear how self-selected supervisors challenged and addressed performance management issues.
- Appraisal completion rates for qualified nurses and health care workers were 100% for Ferguson ward and 73% for Church and Fenwick wards. Nurse managers advised that staff only received managerial supervision twice a year, linked to the appraisal process. Revalidation for doctors on all three wards was 100%.
- From data provided, Church and Fenwick ward had staff who were suspended or under supervision in the 12 months prior to the inspection. Nurse managers advised they had no staff suspended or under supervision at the time of the inspection visit.

Multi-disciplinary and inter-agency team work

- The wards held regular two weekly multidisciplinary team meetings. These meeting offered staff the opportunity to discuss clinical cases and review incidents.
- We attended the morning handover meeting on Church and Fenwick ward. Night staff provided basic information about the patients, their behaviour and compliance with meals and medication for the previous shift. No information on risks, observation levels or safeguarding concerns was discussed. This was of particular concern as two staff on the shift were agency staff, unfamiliar with the ward environment or patient group. One of the nurses was late into work, and unable to attend the morning shift handover meeting. We did not observe provision of a separate handover for that staff member. We observed one of the agency staff on escorted grounds leave with an unfamiliar patient later in the day. On Church ward the night staff completed an electronic handover sheet, which they printed and used as a source of reference in the handover. Staff could access the printed sheet throughout the next shift held in a folder in the nursing station. However, a healthcare assistant gave handover as there had been no qualified nurses on the night shift. Staff did not discuss observation levels for each patient during this handover.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

- On Fenwick ward the night staff completed a hand written sheet. Staff did not discuss observation levels or safeguarding concerns relating to each patient during the handover. Staff present at the handover did not take notes. During the follow up visit to Ferguson ward, we identified that the folder for storage of handover sheets was not up to date.
- We identified examples of poor interagency working in relation to the management and reporting of risks and serious incidents. Staff lacked awareness of the importance of consistent communication with other organisations involved in patient care to ensure collaborative decisions linked to the detention of patients under the Mental Health Act.
- Nurse managers identified the challenges involved with maintaining working relationships with community mental health services as with many patients placed from out of county.

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

- St Andrews had a target for mandatory training compliance of 95%, with attention reportedly given to wards where compliance was 90% or below. Data provided prior to the inspection details mandatory training for the men's pathway which includes the rehabilitation wards with completion rates for Mental Health Act training at 89%.
- Mental Health Act paperwork was scrutinised and scanned onto the provider's electronic records system by the Mental Health Act administration team. T2 and T3 paperwork in relation to consent to treatment linked to patient medication records. Paperwork was in order for the records we reviewed.
- Patient leave entitlement was clearly documented in their records and outcomes from leave placed in progress notes. However, we identified examples of poor risk assessment completion prior to leave and in relation to activities completed during patient's escorted leave with staff. We identified some potentially punitive approaches to leave in relation to compliance with treatment for physical health conditions. We found examples in patient's records where staff told patients they could not have leave due to non-attendance at ward based meetings.
- Occupational therapists worked closely with patients, designing weekly activity programmes, with leave entitlement factored into the plans.
- From the 14 patient records examined, all contained a document to indicate that patient's had their rights under the Mental Health Act explained to them, and reviewed every six months, with a reminder setting in place on the electronic records system.
- Patients had access to advocacy and independent mental health advocates based on the hospital site for support with complaints and tribunals. Information leaflets on services including advocacy were on display in ward areas.
- Nurse managers told us that the Mental Health Act administration team completed audits of Mental Health Act paperwork and took appropriate action for any issues.

Good practice in applying the Mental Capacity Act

- St Andrews had a target for mandatory training compliance of 95%, with attention reportedly given to wards where compliance was 90% or below. Data provided prior to the inspection details mandatory training for the men's pathway which includes the rehabilitation wards with completion rates for Mental Capacity Act training at 82%.
- For the five months prior to the inspection, up to the 31 January 2017 there had been no Deprivation of Liberty Safeguards applications or authorisations for the three rehabilitation wards. We sourced verification on this during the inspection. All the patients on the rehabilitation wards were detained under the Mental Health Act.
- Staff on Church ward identified patients assessed to lack mental capacity to make decisions in relation to aspects of their care and treatment. The multidisciplinary team completed mental capacity assessments. Staff on Ferguson and Fenwick wards did not identify any patients assessed to lack mental capacity. The quality of some consent to treatment records lacked detail in relation to the patient's ability to weigh up and retain information related to the question.
- Patient medication records contained consent to treatment paperwork.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Good

Following our inspection in June 2016, we rated these services as good for caring. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Following our inspection in June 2016, we rated these services as good for responsive. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Inadequate

Vision and values

- The provider's vision was

"Transforming lives by building world class mental healthcare services".

Their values were:

Compassion; accountability; respect and excellence.

- Some staff were not aware of the provider's vision and values varied across the wards and level of time they had been in post.
- Staff knew the most senior managers in the organisation, and spoke positively about the support received from the modern matron and director of nursing. Staff reported a sense of disconnect between executive and board level employees, and the wards.

Good governance

- The delivery of high quality care was not assured by the leadership, governance or culture in place. The monitoring and governance processes were not operationally effective to ensure issues were picked up in a timely manner. We identified a lack of effective monitoring and awareness of the infection control issues, poor cleanliness and environment issues. A lack of effective monitoring of record keeping standards particularly in relation to seclusion and long term segregation. We found equipment which had passed its safety testing date. There was a lack of effective risk management processes in relation to ligature points and individual patient risks. The provider had not addressed issues identified in the June 2016 inspection.
- Staff received mandatory training in relation to the Mental Health Act, Mental Capacity Act and Safeguarding. The area of concern identified related to the level of staff yet to complete Management of Actual and Potential Aggression (MAPA) training at 56%. With approximately 44% of the total workforce for the male pathway having not completed MAPA training, each shift consisted of some staff using MAPA techniques and some Prevention and Management of Aggression and Violence (PMAV). The provider explained in the presentation at the start of the inspection that all staff on the Northampton site would be MAPA trained by March 2018. We could not source assurances at a ward level of effective, interim measures used to manage the risks associated with having staff trained into two different techniques.
- Nurse managers did not hold a record of training data for their staff, as the provider held this information centrally. Whilst nurse managers explained they received a reminder when training was due for renewal, they did not have ward level information to use for monitoring staff competency and performance.
- Staff told us supervision was infrequent, with support offered in group rather than one to one sessions. Nurse managers said staff had managerial supervision twice a year, linked to the appraisal process. It was unclear how managers monitored individual performance and professional development effectively. The inspection team identified a lack of individual supervision reflected in clinical judgements made on the ward in relation to areas such as quality of documentation and escalation of risk incidents.
- We reviewed the last three months staffing rosters, and found that staffing numbers per shift were achieved.

However, the skill mix and level of qualified nurses was an area of concern. We identified qualified nurses on each ward who were working as the only nurse on a shift. Whilst these staff reported to feel well supported, their level of clinical expertise and judgement lacked shared decision making and managerial oversight.

- Each ward had a level of administration cover. Administrators supported staff with tasks such as scanning documents onto the electronic recording system, therefore enabling staff to spend more time with patients.
- Due to staffing pressures, frequency of staff meetings varied across the rehabilitation wards. These meetings, along with clinical supervision, were for discussions relating to incidents, dissemination of information for example from complaint investigations, and sharing lessons learnt.
- For the 12 months prior to the inspection, Ferguson ward received one complaint, this was not was upheld or referred to the ombudsman.
- Church and Fenwick wards received three complaints, with one upheld and none referred to the ombudsman. The nurse manager met with the patient's family and resolved the complaint.
- Staff knowledge of safeguarding practices and procedures varied across the wards with a tendency to defer to the ward social worker rather than taking a lead role in the process.
- Nurse managers were unclear of ward and individual key performance indicators used by St Andrews to gauge practice standards on the wards. Each ward produced a monthly performance indicator dashboard, it was unclear if staff understood the content, or if the documents were discussed with staff. Clinical staff were unable to locate this document on Fenwick ward.
- Nurse managers told us they did not submit items to the provider risk register.

Leadership, morale and staff engagement

- St Andrews 2016 staff survey achieved an employee engagement score of 64%, with 86% of staff saying "at St Andrew's we look after our patients/service users with compassion". The survey identified areas of improvement including,' leadership communication, the need for clear communication of the vision and goals and how these relate to the local pathway or function. The need for leadership or empowerment, staff feeling comfortable about having their say, doing the right thing, ensuring there is an environment for empowerment.'
- Ferguson ward reported to have 2% vacancies, 6% staff sickness and 20% turnover of staff. Church and Fenwick wards reported to have 3% vacancies, 4% staff sickness and 4% turnover of staff in the 12 months prior to the inspection. Nurse managers demonstrated awareness of the procedures in place to support staff returning to work, and acknowledged the importance of working collaboratively with human resources and occupational health departments.
- Staff told us they knew how to implement the provider whistleblowing process, and there was a confidential hotline staff could access. Some staff said they feared victimisation or reprisals if they raised concerns, particularly to the senior management team. The wards did not have any bullying and harassment cases under investigation.
- Nurse managers identified staff morale varied across the rehabilitation wards. Some staff reported feeling stressed and burnt-out by work related pressures.
- Staff recognised the value of strong working relationships with their colleagues and the importance of team work. Staff respected nurse managers and confirmed there was an open door policy for accessing support.
- Nurse managers demonstrated some understanding of Duty of candour, and the need to ensure openness and transparency, explaining to patients where applicable when things go wrong. There was limited documented evidence of this.
- We identified areas of clinical practice, where greater management oversight and leadership was required. For example, in relation to ward culture around staffing levels, ward cleanliness, infection control practices and ligature risk audits.
- We identified a lack of collaborative, interagency working, particularly on Fenwick ward. Clinical judgement and decision making in relation to the management of risks required greater management oversight and shared clinical ownership in line with the professional accountability for registered health care professionals.

Good

Wards for older people with mental health problems

Safe	
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are wards for older people with mental health problems safe?

Following our inspection in June 2016 we rated the services as good for safe. We did not plan to inspect this key question on this inspection however, we found the following:

Safe and clean environment

- Foster ward was a fifteen bedded low secure ward for males set in an older building. There were blind spots on the ward that meant staff could not ensure patients' safety. Staff managed these by maintaining a presence in those areas and curved mirrors were in place. The provider had completed and regularly updated a ligature risk assessments on the ward. A ligature point is a place to which patients intent on self-harm might tie something to strangle themselves. We found these assessments included ligature risks but did not include all risks. For example, lead on windows could be used as a slow ligature. This was somewhat mitigated by staff being available to observe patients for the majority of their time on the ward.
- Cranford ward was a seventeen medium secure ward for older males. The ward was set in a modern building designed in a manner that windows do not open. Patients had reduced access to fresh air circulation. The ward used pumped air system. An outdoor courtyard area was available to patients but looked sparse with artificial grass and lacked visual stimulation. The nurse manager had some plans in place to make improvements. We saw the sensory room was decorated for a younger audience and not appropriate for older adults.
- In Cranford ward there was a strong odour of urine in one of the corridors and in a store room. Staff were managing patient's continence care. Staff were aware of this and funding for a refurbishment of one bedroom had been identified. We saw other parts of the ward were clean and well maintained.

Safe staffing

- We looked at staff rotas on both Foster and Cranford wards, and asked the provider for additional staff rotas following on the inspection. The rotas did not accurately reflect the actual hours worked. Bank staff were not included on the rota. On Cranford ward there were 31 staff in total. On an average shift there were eight staff on a long day and five at night. A clinical nurse lead and three nurses, and five healthcare assistants. The nurse manager worked from 9.00 am to 5pm and were not included in the ward hours.
- Two qualified staff members had just returned from long-term sick leave and were working on the ward. A new nurse had been recruited and would join the ward in September. If a patient required two staff this was provided with bank staff or agency. The nurse manager told us there were six staff on long days shift and three at night. Staff told us they had enough staff but upon arriving on shifts, staff would regularly be asked to cover other wards. This meant they were working with less staff. Two patients told us escorted leave and activities were frequently cancelled, due to staff shortages.
- On Foster ward there were 26 staff in total. On the rota we saw on an average shift there were eight staff on a long day and four at night. Staff told us one shift at night was made up of bank staff, however, this was not evident on the rota. There were no staff vacancies. The nurse manager told us there six staff worked long days with five staff on at night. One patient was being

supported at Northampton General Hospital. The nurse manager also had responsibilities for Ferguson ward. The nurse manager worked from 9:00am to 5:00pm and was not included in the ward hours. There was minimal use of bank or agency staff. However, staff told us, staff were regularly asked to go onto other wards to support patients. This left Foster ward short staffed.

- Medical cover was provided by two doctors on site up to midnight. After midnight, one doctor covered the whole site, with a consultant on call. Staff were concerned that there was inadequate medical cover at night that could attend wards quickly in an emergency and carry out seclusion reviews.
- On Cranford ward 58% of staff were not trained in management of actual or potential aggression (MAPA). This training teaches staff management and intervention techniques in a safe way. This resulted in staff having been trained in different methods of physical restraint. Different techniques were being used which may result in confusion between team members.
- In addition staff told us that not all agency staff were trained in MAPA. This meant permanent staff would be required to assist agency staff when managing challenging behaviour.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed 11 care and treatment records for patients. We found staff assessed and planned care for individual patient's needs. Staff completed care plans that gave comprehensive information about how to best care for the patient. We saw positive behaviour support plans which detailed how to manage behaviour. Care plans took account of the views of the family and carers and were personalised and recovery focused. Patients were offered a copy of their care plan.
- Care plans showed that patients received a physical examination on admission and included information of ongoing physical healthcare needs. Patients received an annual health check. We saw effective psychologists and occupational therapist plans for individual patients.
- Staff used electronic patient records. All staff had access to the electronic patient record system, and were able to access, and input patient information.

Best practice in treatment and care

- The provider employed a physical health care team to assist with assessment and management of physical healthcare needs for patients. The team included consultants, doctors, speciality nurses, dentists, opticians, and podiatry services. Staff on the wards we spoke with confirmed input from the team had been a valuable resource for patients care. For example, a nurse specialised in diabetic care and was able to advise staff on individual treatment plans. A monthly report identified patients requiring screening, and patients were encouraged to attend. Staff supported patients to access specialists, as required and escorted patients to appointments, when needed.
- Patients had access to psychology, a dietician, physiotherapy, occupational therapy and effective pharmacy input on wards. Staff assessed and met patients' nutrition and hydration needs.
- Nursing staff completed health of the nation outcomes scales depression scales, standardised assessment and diagnosis scales in dementia. Foster and Cranford wards were older adult's wards, and followed the men's pathway of care, individualised to patient needs.
- The provider monitored and audited outcomes for patients using the service. This included the monitoring of key performance indicators such as length of stay, the use of restraint and rapid tranquilisation.
- Staff on wards completed some audits, for example, audits of infection control and cleanliness audits. The pharmacy team carried out a number of checks and audits, clinical checks of medication records, antipsychotic medicines, controlled drugs, and clinic room audits.

Skilled staff to deliver care

- Wards had a range of disciplines to provide care and treatment. The multidisciplinary team consisted of consultants, speciality doctors (junior doctors), psychologists, qualified nurse's occupational therapists,

and health care assistants. Pharmacy staff were available when needed. Wards had access to social workers on site. However, one patient said the social worker was not accessible "when there was an important situation." Cranford ward patients had regular access to a geriatrician, a specialist physician who deals with the diseases related to old age. Staff were experienced.

- When staff starting work at St Andrew's Healthcare health care assistants were provided with the national care certificate standards induction. The care certificate aims to equip staff with the knowledge and skills which they need to provide safe compassionate care.New staff attended a formal induction period. This involved attending a corporate induction, learning about the ward and policies and a period of shadowing existing staff before working alone. Newly registered staff completed a preceptorship. Preceptorship is a period in which to guide and support all newly qualified practitioners to make the transition from student to registered nurse. We were told that bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks.
- Staff received the necessary specialist training for their role for example end of life training, dementia training and physical health care training. There were opportunities for development for both qualified and unqualified staff. The provider offered the ASPIRE programme to unqualified staff to train as nurses. Qualified staff were offered top up degrees, and masters' degrees, advanced academic or professional training.
- The provider target rate for appraisal rates was 75%. The percentages of non-medical staff that have had an appraisal in the last 12 months on Foster ward was 89% and on Cranford ward 93%. Appraisals is a method by which the job performance of an employee is documented and evaluated. A total of seven doctors worked across older adult's men's service and neuropsychiatry wards, with some doctors working on more than one ward. All seven doctors had completed a medical appraisal in the 2016/17 year ending 31 March 2017. One hundred per cent of doctors had completed their revalidation.
- The provider target rate for clinical supervision of medical staff was 85%. The clinical supervision rate for Foster ward was 80% and Cranford 91%. Foster ward had low take up of clinical supervision over three months, which had reduced the overall average across the year.
- Staff we spoke with received regular supervision on the wards. Nurse managers showed us training records with 100% compliance for supervisions. We found that supervision records contained a mixture of clinical and managerial supervision documentation, for example reflective group sessions, formal one to ones, and clinical discussions.
- The provider had processes for identifying and managing poor staff performance, including involvement from occupational health and the human resources service. The provider information told us that there had been no staff suspended and, or under supervised practice between 1 January 2016 and 31 December 2016 for this core service.

Multi-disciplinary and inter-agency team work

- There were regular and effective multidisciplinary meeting on wards. Patients and their carers were encouraged to attend, participate and share their views. Different professionals worked together effectively to assess and plan patients' care and treatment.
- The consultant and medical staff were a regular presence on the wards and were present at times during our inspection. We observed good interaction between the ward staff and medical teams on the wards.
- We saw how the ward team liaised with other services for example older adult's networks and police. There was effective communication with commissioners, local authority and social workers.

Adherence to the MHA and the MHA Code of Practice

- The Care Quality Commission completed two unannounced Mental Health Act reviews to Cranford and Foster wards. On Cranford ward the issues identified were around respecting patients' rights and autonomy, care support and treatment in hospital, and leaving hospital. On Foster ward, the issues were around respecting patients' rights and autonomy, care support and treatment in hospital. Provider actions plans were in place for these aspects. On Cranford ward, there was a seclusion room review in May 2017 and a report was being drafted. The provider had completed works to update the seclusion room.

Good

Wards for older people with mental health problems

- For the older adults men's pathways there were 82% staff trained in the use of the Mental Health Act 1983 and Code of Practice. Mental Health Act training was provided annually. The clinical nurse lead and nurse managers showed us staff training records. The staff group were 100% compliant in Mental Health Act training. The provider had ensured that staff were appropriately trained for their role.
- Two patients told us they could not always access activities off the ward or Section 17 leave due to staff issues.
- We observed a pre-discharge meeting on Foster ward. This was in line with Section 117 aftercare services Mental Health Act 1983.The meeting was arranged to plan aftercare arrangements for a patient leaving hospital. The patient, two carers and twelve staff attended. We found the meeting was exemplary and observed staff share information and discuss plans with the patient; and worked together to plan the patients aftercare.
- Staff we spoke with were aware of their responsibilities under the Mental Health Act and knew where to get further advice, if needed.
- Staff completed mental health act paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place.
- We checked eight medicine charts. Medical staff completed consent to treatment and capacity requirements. Nursing staff had access to T2 (consent to treatment) and T3 (is when patients do not consent) when administering medication for patients.
- Mental Health Act administrators were available to offer support and legal advice to staff on the implementation of the Mental Health Act and its Code of Practice. The Mental Health Act administration office provided reminders to consultants for section renewals and consent to treatment. The Mental Health Act administrators were a point of contact for staff to seek advice about Mental Health Act.
- Nursing staff checked and received detention papers. The Mental Health Act administrators completed scrutiny of section papers to ensure compliance with the Mental Health Act and regular audits.
- We saw information on the wards around access to Independent Mental Health Advocacy.

Good practice in applying the MCA

- Training records showed that staff were 100% in the use of Mental Capacity Act 2005 (MCA). The provider had ensured staff were appropriately trained for their role. Most staff we spoke with explained how capacity would be assessed for significant decisions. However, staff told us nursing staff usually completed assessments.
- The provider had a Mental Capacity Act and Deprivation of Liberty Safeguards policy for staff reference. Staff we spoke with had varying degrees of knowledge about the Mental Capacity Act and Deprivation of Liberty Safeguards process. The provider ensured that staff were appropriately trained for their role.
- Staff told us capacity assessments were usually completed by nursing staff. On Foster ward one patient had a completed Deprivation of Liberty Safeguards application. Best interest assessments were completed when necessary.
- Staff told us they would seek advice from the clinical nurse lead, nurse manager and the Mental Health Act administrators were a point of contact to seek advice about Mental Capacity Act.

Are wards for older people with mental health problems caring?

Good

Following our inspection in June 2016, we rated these services as good for caring. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Good

Following our inspection in June 2016 we rated these services as good for responsive. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.

Good

Wards for older people with mental health problems

Are wards for older people with mental health problems well-led?

Good

Vision and values

- The provider's vision was:

"Transforming lives by building world class mental healthcare services".

Their values were:

Compassion; accountability; respect and excellence.

- Staff we spoke with were aware of the organisation's values. Staff identified that these were available on the providers intranet system and were highlighted in yearly appraisal meetings and training.
- Staff we spoke with knew who the local senior managers in the organisation were. Staff told us that senior executive management team were not as visible and had not visited the wards.
- Staff felt well supported by clinical nurse leads and nurse managers.

Good governance

- The provider failed to identify staff shortages on Foster and Cranford ward and the impact on patient care as some patients told us they were unable to take Section 17 leave. Although staff rotas showed wards had the required staffing levels, staff would be "borrowed" to cover wards at short notice. Staff consistently told us about their concerns for medical cover at night with one doctor on call after midnight.
- The provider had processes for ensuring all staff had received annual appraisals. Data showed the appraisals rates were all above 75% for both medical and non-medical staff. We saw training records on wards that confirmed staff had made progress and were up to date with appraisals and supervisions. Staff received mandatory training including MAPA training.
- Staff participated in regular clinical audits infection control and cleanliness audits; and incidents were reported. Staff were debriefed after serious incidents. However, serious incident reports were not routinely being made available to clinicians so we were not assured learning took place.
- We found Mental Health Act paperwork to be in order and accessible to staff for reference. Staff had received training in the use of the Mental Health Act across all wards. The trust completed regular audits to ensure Mental Health Act paperwork was in order. Staff received training in the Mental Capacity Act and had varying degrees of knowledge about processes.
- Nurse managers had access to administrative support and had sufficient authority to manage their wards. Both nurse managers covered two wards. Nurse managers told us senior managers supported them in their role.

Leadership, morale and staff engagement

- No staff spoken with reported concerns with bullying or harassment. The provider had a whistleblowing policy and all staff told us they felt able to raise concerns with managers without fear of victimisation. An independent confidential reporting line -safecall was also available for staff to report risks.
- Overall, morale amongst staff across the older adult's men's pathway was good. Most staff we spoke with said they felt well supported by their immediate manager. On both wards, we saw a positive working culture within the teams. However, some staff told us they had been concerned about two senior clinicians that had recently left the service abruptly. This had impacted on staff morale and staff anxiety.
- Staff spoke passionately about the patient group. There was a culture of high quality sustainable care, which was corroborated with staff interactions with patients and care records.
- Staff reported good team working and told us they felt supported by their colleagues in their work. There were opportunities to give feedback about the service. There was good leadership on all wards. Nurse managers had access to leadership courses.
- Staff could nominate teams and individual staff for awards. Cranford ward team were nominated for a Best Team award and were due to attend an awards ceremony in May 2017.
- Staff told us they completed an annual employee engagement survey. A survey had just been completed in 2017 but had not been fully analysed. However a

Good

Wards for older people with mental health problems

senior management team member told us for 2017 two areas identified were to improve staff engagement, and patient and carer engagement. In 2016 the survey identified the top three issues: the re-introduction of management drop in sessions for staff to meet operational managers, regular planned time on wards by operation managers, and site wide plans and changes to be included in monthly staff meetings. The latest survey showed an average engagement score of 64%. This was 5% higher than the 59% engagement score in 2015, which meant more staff were completing the survey.

Commitment to quality improvement and innovation

- Foster and Cranford wards were part of the quality network for inpatients accreditation for the men's secure service. The last peer review of these services was in February 2016 and a further review took place in April 2017. The men's service fully met 93% of medium secure standards. However 100% of criteria was achieved in admissions, discharge, procedural, security, relational security, safeguarding and family and friends. Areas identified for improvement were environmental and facilities, physical healthcare, and workforce.

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- Staff observed patients in all areas of the wards. Lines of sight were good and staff constantly observed any areas where lines of sight from the nursing office were obstructed. For example, in bedroom corridors.
- The provider carried out regular ligature audits for all areas on each ward. The clinical risk manager completed audits six monthly or after maintenance staff had carried out work. Staff mitigated these through environmental risk management for each patient. The ligature audit was up to date. We requested to see copies of ligature risk assessments and staff could not locate them easily on all wards.
- Clinic rooms were equipped with a couch, scales and blood pressure monitors. Medications and resuscitation equipment were available in case of emergency. Staff completed weekly checks, however, in some cases staff had recorded equipment checks as complete but this was not the case when looked at by the inspection team. For example, we found out of date dressing in the first aid box.
- Emergency equipment and medication was shared between three wards, which had to be accessed through locked doors. This meant that there could be a delay in accessing equipment or medication in an emergency. However, the provider completed regular emergency response exercise and they made the required time on all occasions.
- We reviewed two seclusion rooms and found that they met the standard as outlined in the Mental Health Act code of practise.
- The provider carried out monthly environmental audits to check conditions, appearance, maintenance and cleanliness. The recent audit identified all areas that needed repairing and cleaning. The hospital had a maintenance team carrying out these duties across the hospital.
- Staff had access to infection control equipment. For example personal, protective equipment. In addition, staff carried out infection control audits every three months. An external infection control nurse carried out yearly audits. The infection control policy was in date.
- Equipment was well maintained and staff completed regular check to ensure all equipment was in working order.
- Cleaning staff ensured that they cleaned the wards regularly. They kept up to date records.
- Across all wards staff had access to alarms which they carried on their belt and if activated pinpointed their location. Across the site, staff called for further assistance using a radio. In each patient bedroom there was a nurse call system for patients to summon help if required.

Safe staffing

- Hawkins ward reported establishment figures of 8.7 whole time equivalent (WTE) qualified nurses and 24.9 whole time equivalent health care assistants. There were 2.5 nurse vacancies and 2.4 healthcare assistant vacancies. Mackaness ward reported establishment of 6.8 whole time equivalent qualified nurses and 15 healthcare assistants. There were 4.3 nurse vacancies and 6.1 healthcare assistant vacancies on this ward, this

meant only 2.5 qualified staff were in post. Harlestone ward had 13.7 whole time equivalent qualified nursing staff, with 24.7 nursing assistants. There were 2.5 qualified nurse vacancies and one nursing assistants. Lastly, Naseby ward had 9.3 qualified nursing staff, with 1.8 vacancies. In the data provided prior to the inspection, there were 12.5 healthcare assistants with 6.6 vacancies, however, at the time of the inspection there were 17 in post and three vacancies. Minutes of a monthly assurance board meeting in December 2016 reported 42 registered nurse vacancies across the learning disabilities/autistic spectrum disorder (ASD) pathway for all the St Andrew's sites (male and female wards). Managers estimated 18 of these vacancies were for the Northampton site.

- From 1 November 2016 to 31 January 2017, bank staff filled 3662 shifts across the learning disability and ASD wards. Managers used regular bank and agency staff, where possible, to ensure consistency of care for patients. From 1 November 2016 to 31 January 2017 510 (12%) shifts were not able to be filled by bank or agency staff.
- From 1 February 2016 to 31 January 2017 Hawkins ward reported 6% sickness, Naseby had 6% sickness, Mackaness 7% sickness and Harlestone reported 3% sickness.
- There was a high turnover rate on some wards. For the same time period staff turnover on the wards was as follows: Hawkins 6% which related to two staff leaving, Naseby 23% which related to five staff leaving, Mackaness 18% relating to four staff leaving and Harlestone 3%, which related to one staff member leaving. Whilst turnover was high on some wards this was being managed to mitigate any risk to the safety of the ward.
- Managers on each ward had specific requirements for the amount of nurses required per shift. Managers based this decision on the level of care required by the patients on the ward. Managers tried to ensure that when they booked bank or agency staff they were familiar to the ward.
- On Naseby ward when we visited at 7.30am we found the ward had five unfilled shifts in the afternoon. These had either been out to bank or agency for some time and had not been filled, and some staff had phoned in sick. However, by the afternoon there were only two health care assistants down. The senior manager acknowledged that although this was not ideal the wards worked well across the pathway and the nurse manager felt that the ward was safe and was supported by colleagues from across the pathway.
- Qualified staff were present on all wards visited during the course of the inspection.
- Staff cancelled section 17 leave and patient activities when there was not enough staff on the wards. Staff told us that this was a last resort and it was usually staff breaks that were cancelled first before leave and activities. Managers and staff did not record cancellation of leave, activities or staff breaks in a formal way, therefore the hospital could not monitor the impact of staffing levels on these issues.
- Doctors provided medical cover across the wards and staff could contact medics out of hours by following the rota in place.
- 93% of staff received mandatory training. The hospital target for mandatory training was 95%. Some staff had also received specific training in positive behaviour support planning.
- 51% of staff received training in management of actual and potential aggression. The provider was in the process of training all staff in the management of actual and potential aggression (MAPA). This would replace the previous training of prevention and management of aggression and violence (PMAV). MAPA places emphasis on de-escalation and prevention of aggression. Staff who had not yet completed MAPA had previously been trained in PMAV. However, not all staff had received PMAV in the last 12 months. Due to the changeover this meant it was possible staff were trained in different techniques for restraint, as managers did not review staff training when planning shifts.

Assessing and managing risk to patients and staff

- From 1 August 2016 to 31 January 2017 Hawkins ward had 49 incidents of use of seclusion and three patients were segregated long-term. On Naseby there were 55 seclusions, with one patient secluded long term. On Mackaness there were 60 uses of seclusion and on Harlestone three. Mackaness and Harlestone had did not use long term segregation during this time.
- For the same time period, staff used physical restraint 199 times in the service. This was 59 times on with13 different patients on Hawkins ward. Thirty eight of the restraints were in the prone (face down) position and 12 of the prone restraints resulted in rapid tranquilisation.

On Naseby ward staff restrained 50 times on 11 different patients. Fourteen of the restraints were in the prone position and none of the restraints resulted in rapid tranquilisation. On Mackaness ward, staff restrained 85 times on 12 different patients. Of the restraints, 34 were in the prone position and five resulted in rapid tranquilisation. Harlestone ward restrained five times on four different patients. None of the restraints were in the prone position and none resulted in the use of rapid tranquilisation. Data showed a downward trajectory of between 1% and 2% compared with data from the February 2017 focused inspection. The provider reported there was a gradual downward trend in the use of restraint across the site. They reported a reduction in restraint by 32%, and a reduction in the use of prone restraint by 38%. According to the provider the use of seclusion had decreased by 17%.

- We looked at 32 records case records and found that risk assessment were completed on admission and routinely thereafter including after incidents.
- Staff used the short-term assessment of risk and treatability and the historical clinical risk management 20 risk assessment tools.
- Blanket restrictions were not routinely used within this service. If they were used they were justified on the individual risks posed by the patient.
- Managers did not comply with the hospital observation policy when allocating staff to patient observations. We found examples of staff observing patients one to one for up to five hours.
- Staff recorded within patient case records that they used verbal de-escalation prior to the use of restraint.
- Staff used rapid tranquilisation in line with National Institute for Health and Care Excellence guidance.
- We looked at seventeen seclusion records and found that all had information missing. Staff did not complete seclusion records in full. There were gaps on seclusion registers, including the length of the seclusion. Managers introduced seclusion 'packs' but staff did not consistently complete these across the wards. Staff scanned seclusion packs onto the electronic records that were blank. Staff recorded seclusion entries on the electronic system before seclusion had commenced. Therefore, it was not clear that the records were always accurate. Doctors did not review all patients within one hour of seclusion starting.
- Data showed 94% of staff were trained in safeguarding. Staff we spoke with could describe how to raise a safeguarding alert. They also reported that they would seek guidance form the wards social worker if they were not sure.
- We found that medicines were stored securely in the clinic room. Stock and individually dispensed medicines were administered in line with local policies. If patients were allergic to any medicine, this was recorded on their prescription chart. Pharmacy audit the medication charts and highlighted any errors or omissions. Patient information leaflets were available via the internet.
- However, we found issues relation to the administration and storage of medication on Mackaness ward. Staff did not take or record appropriate action when fridge temperatures were outside accepted range on nineteen occasions. The medication charts were not always clearly written and we could not always determine which route was used to administer the medicine to the patients, therefore we could not be assured that the record of administration was accurate. In addition, we found that one patient had been administered a higher dose more of a medicine used for managing behaviour than was prescribed over a 24 hour period. Staff did not dispose of out of date nutritional supplement drinks.
- There was a family room in the building for visiting to take place and the social worker carried out an assessment prior to children visiting the ward.

Track record on safety

- In the 12 months prior to the inspection there were a total of 17 serious incidents across the wards. Hawkins staff reported six incidents, which related to allegations of abuse by a third party, aggressive and violent behaviour and one recorded as 'pending'. Naseby ward staff reported two incidents, both relating to information governance breaches. Mackaness staff reported three serious incidents relating to environmental incidents and medication incidents. Harlestone staff reported six incidents relating to allegations of abuse by staff, self-inflicted harm and unauthorised absence. All incidents were investigated and appropriate action taken.

Reporting incidents and learning from when things go wrong

Requires improvement

Wards for people with learning disabilities or autism

- Staff reported incidents using an electronic system. Staff reported all incident that need to be reported. Managers reviewed incidents and investigated where required to identify any learning.
- Staff were aware of the Duty of candour and were open, transparent and explained to patients when things went wrong.
- Staff did not always receive feedback from investigation of incidents that were internal or external to the service.
- Managers ensured that staff were debriefed and offered support after serious incidents. Psychologists also offered support.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We reviewed 32 care and treatment records, staff completed a comprehensive assessment of risk during a multidisciplinary team meeting within 72 hours of each patient's admission.
- Staff completed an initial physical healthcare examination on admission and monthly thereafter.
- Staff completed comprehensive care plans with patients, that addressed holistic and recovery orientated goals.
- Staff recorded daily interactions with patients on the electronic system. Most records demonstrated person centred care. However, there were examples of staff adopting a punitive approach to patients in three of the records we reviewed. For example, cancelling leave for a reason not related to individual risk.
- Staff recorded information about patient care on an electronic record. However, not all information was easy to locate and there was a lack of consistency about where certain information should be stored.
- Every case record had a positive behaviour support plan in place. Staff wrote this in conjunction with the patient. They were comprehensive and covered a range of needs. Staff provided easy read versions for the patients.

Best practice in treatment and care

- Doctors prescribed most medication in line with National Institute of Health and Care Excellence guidelines and monitored any high doses of anti-psychotic medication. Staff completed care plans to support prescribing which included monitoring instructions and a rationale for prescribing. However, all 17 medication charts had lorazepam prescribed, indicating that lorazepam was routinely prescribed and not individually assessed. We found that in all cases this had not been administered to the patient and questioned why it remained on the medication chart.
- Psychologists supported all wards and offered structured psychological therapy to patients. This included one to one sessions and group therapy.
- Staff supported patients to access appropriate physical healthcare. Staff referred patients to physical health teams and dentists, when appropriate. Staff completed annual physical health checks with patients and used information from this to complete health action plans.
- Staff monitored any identified ongoing health needs, such as asthma and heart conditions. Staff recorded how conditions should be managed and recorded checks in the electronic notes. Staff highlighted medical conditions by creating alerts on the electronic system.
- Staff completed nutrition and hydration needs assessment where appropriate.
- Staff completed health of the nation outcome scales to assess and record severity outcomes for patients.

Skilled staff to deliver care

- Managers allocated a mix of qualified staff and healthcare assistants to each shift to ensure there was a suitable mix of skills and experience to meet the needs of the patients. Members of the multidisciplinary team delivered education sessions in team meetings to increase staff knowledge in specific areas relevant to the patient group.
- The hospital provided a structured induction to all new staff prior to them starting work on the wards.
- Managers offered staff regular clinical supervision. On average 82% of staff across the service had received supervision. Managers recorded dates supervision took place and provided this information to senior management. The hospital did not have a formal policy for line management supervision to discuss staff performance. Managers told us that any performance conversations would be addressed in one to one sessions that would be arranged as and when required.

Requires improvement

Wards for people with learning disabilities or autism

As of 3 February 2017, 93% of staff on Hawkins ward had received an appraisal, 82% of staff received an appraisal on Mackaness ward, 86% of staff on Harelstone received an appraisal and all staff on Naseby received an appraisal.

- Managers did not record regular team meetings on all wards. Managers could not provide records which showed meetings took place at the required frequency of one meeting per month.

Multi-disciplinary and inter-agency team work

- The multidisciplinary team consisted of doctors, nurses, psychologists, occupational therapists, speech and language therapists and social workers.
- There were multidisciplinary meetings weekly. Managers discussed patient incidents, reviewed medication and treatment plans. Staff supported patients to attend these meetings. Staff liaised with external agencies when appropriate. Staff recorded discussions with local care co-ordinators to update them about patients' treatment. There were care treatment reviews held with the commissioners to discuss each patient's treatment.
- Staff met to handover information about patients at the start of every shift. Staff discussed any information relating to patient activities and risk. We observed two handover meetings and found that they were comprehensive.
- We found evidence in patients case records that there was effective working with team outside of the organisation in relation to discharge planning and to provide updates to commissioners.

Adherence to the MHA and the MHA Code of Practice

- The hospital provided mandatory Mental Health Act 1983 (MHA) and Mental Capacity Act training. Training records showed 82% of clinical staff in the men's pathway completed this as part of their induction as an online learning.
- Mental Health Act paperwork was in order for the records we reviewed, with patient leave entitlement clearly documented and outcomes from leave placed in progress notes. Patient's had their rights under the Mental Health Act explained to them, and reviewed every six months, with a reminder in place on the electronic records system. Patient medication records contained T2 and T3 paperwork in relation to consent to treatment.
- Electronic care records were poor in many cases and it was not possible to track the actions undertaken during seclusion or long term segregation. Associated paperwork such as observation records, care plans, risk assessments were not routinely filed on the system or available on the wards.
- Patients had access to advocacy and independent mental health advocates based on the hospital site for support with complaints and tribunals.
- Nurse managers told us that the Mental Health Act administration team completed audits of Mental Health Act paperwork. Staff could seek advice when required.
- The long term segregation policy did not meet the code of practice in respect of review requirements. We found that staff were confused about what constituted seclusion and long term segregation.

Good practice in applying the MCA

- Data provided prior to the inspection detailed mandatory training for the men's pathway with completion rates for Mental Capacity Act training at 82%.
- Staff discussed patient capacity during ward rounds and this was recorded on the electronic record. Staff described the principles of the Mental Capacity Act and gave examples where capacity was assessed appropriately. Staff recorded best interest decisions where patients lacked capacity.
- Staff recorded discussions with patients about medication and treatment on the electronic records.
- The provider carried out audits into the adherence to Mental Capacity Act. Staff could access the policy and advice when required.
- The provider had a Mental Capacity Act and Deprivation of Liberty Safeguards policy for staff reference.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

Requires improvement

Wards for people with learning disabilities or autism

- Most interactions that we observed were of staff supporting and engaging with patients in an active and positive manner. Although this was mostly true on Harlestone ward, we did observe two instances of staff taking a long time to acknowledge requests from patients for assistance.
- Patients said that staff treated them well, but they felt that staffing levels affected how much they could do. They told us that activities were cancelled sometimes and staffing levels could affect how often they could take leave. The provider did not monitor this.
- Staff knew patients preferences and ways in which they were best to support patients with their needs.

The involvement of people in the care they receive

- Staff ensured that when patients were admitted to the ward they showed them round to orientate them and informed them of medication and meal times.
- Staff recorded the patient voice in care plans and positive behaviour support plans. Patients were encouraged to attend multidisciplinary meetings to discuss their treatment plan with the team.
- Patients had access to advocacy. We found evidence in case records that the advocate supported patients to raise concerns or complaints.
- Staff supported families and cares involvement in the patients care when appropriate. This included visiting the ward and regular updates on patient's health. Staff supported patients to attend care and treatment reviews and there was evidence in records that changes to treatment were made based on recommendations from the meeting.
- Patients were able to give feedback on the service they received in the form of a survey or through community meetings. However, not all concerns raised were addressed by staff.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

- Average length of stay on each ward over six month was, 1064 days on Hawkins, 1470 on Naseby, 1147 on Mackaness and 1413 on Harlestone. The learning disabilities and autism wards services have a high number of patients, 75%, on a forensic section, often with restrictions. The provider reported there can be a delay in the time for approval for admission, transitions, and discharges from the Ministry of Justice. St Andrew's Healthcare records the length of stay from admission to the hospital to discharge from the hospital and do not separately report stays on medium and low secure wards.
- The hospital accepted patients from all parts of the country. If possible, patients were discharged to a suitable placement closer to home.
- If required, staff would make appropriate referrals to other services if the patient's risk presentation changed.
- Staff ensured that when patients were moved wards or discharged this happened at an appropriate time of day.
- Staff discussed discharge with patients during ward rounds and care plans. The discussion included steps for patients to work towards to achieve discharge from hospital. Where possible, patients moved through wards within the hospital, when they became more independent and required less support from staff. The provider recorded this as one length of stay. Discharge planning formed part of the care treatment reviews.
- Staff were aware of and could discuss the national strategy specific to learning disability patients, including the transforming care agenda.
- In the last six months there have been two delayed discharges. This was owing to funding not being approved in a timely way.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards provided patients and staff with a wide variety of rooms to support treatment. This included sensory rooms and low stimulus environments.
- Staff supported patients to arrange family visits and these could take place on and off the wards.
- Patients had access to private telephones to make calls.
- All wards had access to outside space. Harlestone ward could not support patients with mobility issues to access outside space due to steps. However, there were no patients with this need living on the ward at the time of the inspection.

- Patients had access to hot drinks and snacks. Where access to this was restricted by locked doors, staff would support patients to access this when required.
- Patients were able to personalise their rooms using pictures and photographs.
- Activity co-ordinators planned activities for patients during the week and at weekends. This ran alongside patient's therapeutic sessions with psychology.

Meeting the needs of all people who use the service

- Wards provided access for people with mobility difficulties. One garden was not accessible. However, patients with mobility difficulties were not admitted to that ward.
- Staff had forms and information leaflets in a variety of formats, including easy read and pictorial. Secure noticeboards were in place.
- Staff had access to the use of a language interpreter if needed.
- The hospital provided a menu for patients to choose a variety of meals each day, this menu had healthy options available. Patients said they liked the food. Food choices for religious and cultural needs were catered for.
- Within the hospital, patients could use a visiting room or quiet area as a multi-faith room. Chaplaincy support was available and staff supported patients to access places of worship when required.

Listening to and learning from concerns and complaints

- The provider received four complaints on Hawkins ward, one on Naseby, seven on Mackaness and 11 on Harlestone in the last 12 months. Seven were upheld. No complaints were referred to the public health service ombudsman.
- Patients knew how to make a complaint. If not staff would request that the advocate support them in raising their concerns,
- Staff new how to handle complaints appropriately. Managers ensured that staff received feedback of the outcome of complaints in the majority of cases.

Are wards for people with learning disabilities or autism well-led?

Good

Vision and values

- The provider's vision was:

"Transforming lives by building world class mental healthcare services".

Their values were:

Compassion; accountability; respect and excellence.

- Staff were committed to the patients. They supported and communicated about patients in a way that reflected the organisation's values.
- Staff told us that senior managers were more visible since the last comprehensive inspection and had visited the wards.

Good governance

- An electronic system allowed senior staff to monitor compliance rates with mandatory training.
- Staff received regular clinical supervision. Manages provided dates to senior managers as to when supervision had occurred. Managers did not keep records of supervision; therefore it was not clear what topics were discussed and if actions were completed. Managers did not deliver formal line management supervision to discuss staff performance. Performance issues were addressed 'as and when required' through one to one discussion. The provider did not have a clear expectation regarding management supervision.
- Staff received yearly appraisals of their performance.
- Managers did not arrange regular and effective team meetings for staff across all wards. Workload and capacity had affected the ability for meetings to be arranged.
- Managers did not formally record the impact of staffing on patients and staff. Staff were not always able to take breaks and patient activities and leave were cancelled when staffing levels were low.
- Staff told us they did not know the rationale for some new procedures. For example, staff were not sure which seclusion paperwork to follow or how to complete it, where a record of handovers needed to be kept and why other paperwork changes had been made.

Leadership, morale and staff engagement

Requires improvement

Wards for people with learning disabilities or autism

- The 2016 staff survey achieved an employee engagement score of 64%, a five point increase in comparison to 2015.
- Key highlights were:

86% of staff said "I am willing to give extra effort to help St Andrew's meet its goals"

86% of staff said "At St Andrew's we look after our patients/ service users with compassion"

84% of staff said "In my team, we constantly look for ways to do our jobs better"

- Areas for improvement were identified as:

leadership communication – clear communication of the vision and goals and how these relate to the local pathway/ function,

leadership / empowerment – feeling comfortable about having their say, doing the right thing, ensuring there is an environment for empowerment,

reward – focus on reward and ensure that people feel valued,

perception of low staffing, bureaucracy – addressing perceptions of low staffing, bureaucracy and existing processes.

- Staff sickness was from 3% to 7%. We were told by staff that sickness related to being the victim of an assault by patients and work related stress. Staff referred to feeling 'burnt out'.
- A theme from discussions with all staff groups was that admissions were not always clinically led. We were given examples of when a clinician's decision had been overridden by non clinicians. This posed a risk of inappropriate admissions.
- Staff were aware of the provider's whistleblowing policy, some staff felt unable to report concerns for fear of repercussions.
- Staff said although morale was low, they felt they got on well as a team and supported each other when needed. Staff liked working with each other and with the management team on their ward.
- There was a leadership development programme available to staff at ward manager level and above, with plans to roll this out to other grades in the future.

Commitment to quality improvement and innovation

- The hospital was participating in the Royal College of Psychiatrists quality network for inpatient learning disabilities services; this was a standards based quality network to facilitate good practice across similar services nationally.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the environment is well maintained, safe and that it is clean. The provider must ensure all patient risk assessments and care plans include how staff will manage specific environmental ligature risks.
- The provider must ensure the prevention, detection and control of infection.
- The provider must ensure the governance processes are operationally effective and identify issues.
- The provider must ensure there are sufficient numbers of suitably qualified, competent, skilled, and experienced persons deployed to meet the needs of all patients using the service, including adequate medical cover at night.
- The provider must ensure policies meet the Mental Health Act code of practice and that staff are fully aware of terminology and required practice.
- The provider must ensure accurate, complete and contemporaneous records are kept.
- The provider must ensure that privacy and dignity is maintained at all times.
- The provider must ensure equipment is up to date with safety testing and within expiry dates.
- The provider must address the issue of staff being trained in two types of physical intervention approaches to ensure staff and patient safety.
- The provider must ensure the proper and safe management of medicines and ensure prescribing is in line with the National Institute of Health and Care Excellence guidance.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Ligature audits did not identify how to mitigate risks. Individual risk assessments were not always up to date or updated following an incident. • Staff lacked understanding of some of the risk issues associated with patients' property. • We identified some issues around medicines management. • Ensuite and communal bathrooms on Church ward smelt very strongly of drains making it unpleasant for patients to use. This was a breach of regulation 12.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Records did not always document discussion around a patient's capacity. • Records of ongoing physical healthcare monitoring were poor in all but older people's and learning disabilities services. • The long term segregation policy did not meet the Mental Health Act code of practice in respect of review requirements. For example, the long term segregation policy allowed for the nurse in charge, rather than an approved clinician, to review the patient daily, and allowed for another division of the hospital (rather than an external hospital) to undertake the three monthly reviews.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 17.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Staffing levels did not meet the required number on each ward to meet the individual needs of the patients. The highest vacancy rate was for Prichard at 17.8%. • We found that not all shifts were filled, and there was not the required amount of qualified staff on duty. The percentage of shifts not filled to cover nurses absences was 16% for the psychiatric intensive care unit (120 out of 858 shifts), 15% for rehabilitation wards (45 out of 387 shifts), 12%(5120 out of 4,230 shifts) for the learning disabilities wards and 6% for forensic wards. • The provider did not ensure that there was sufficient leadership at a ward level. One nurse manager was responsible for three wards, Church, Fenwick and Fairbairn. Another was responsible for two wards, Ferguson and Foster. This reduced the ability to provide managerial oversight and provision of robust clinical supervision and reduced ability to assess, monitor or improve the ward environments. This was a breach of regulation 18.

This section is primarily information for the provider

Enforcement actions

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 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • On Robinson ward and Fenwick ward staff monitored patients in seclusion by viewing television screens displaying closed circuit television footage for the bedroom and bathroom of the seclusion room. All seclusion rooms' monitors looked directly over the toilets. This impacted on patient dignity, the patient could be seen whilst on the toilet and all staff accessing the corridor leading to the seclusion rooms could view the screens, not just the staff monitoring seclusion. • On Ferguson ward, staff locked patients in the toilet area of the seclusion room when they needed to enter to the room. For example, for staff to enter to give the patient a meal or a drink. They then unlocked the door from the toilet when the staff had left seclusion. This is contrary to the principle of respecting patients which is in the Mental Health Act code of practice. This was a breach of Regulation 10.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The standards of cleanliness were poor and the issue had not been identified through the audits. Ferguson ward was visibly very dirty. Ledges, joins between floor and wall and handrails had thick coatings of dust and dirt on them. Toilets were blocked with effluent flowing back into the toilet bowl. Shower rooms smelt strongly of drains. Bedroom walls had

Enforcement actions

exposed plaster, and sealed flooring was detached from the walls and contained dirt. The housekeeping cupboard contained used mops, left in buckets containing dirty water.

- On Ferguson ward staff did not follow the care plan and risk assessment of a patient who required specialist wound care. In addition, they did not adhere to specific infection control procedures for this patient. Staff did not recognise the importance of these treatment practices.
- Handovers did not provide information in relation of the observation levels for each patient during the handover. Staff in the handover did not discuss observation levels or safeguarding concerns relating to each patient and those present at the handover did not take notes. During the follow up visit to Ferguson ward, we identified that the folder for storage of handover sheets was not up to date. This meant staff did not have a documented comprehensive handover which identified risk and the observation levels required. This put patients and staff at risk because staff did not know the risks each patient presented.
- On Ferguson ward the door to the seclusion bedroom opened onto the main bedroom corridor. This posed a risk to other patients if they were in the vicinity of the bedroom corridor when staff opened the seclusion room door.
- The risk management processes were not effective. The provider did not ensure that patients' risk assessments identified all the patients' risk factors and that they were updated following incidents. We found an example of this in the forensic service. A patient tampered with the electrical wiring in the bedroom causing the lights and the electrical supply to fuse. The provider did not ensure that immediate action was taken to make the room safe, the patient was not moved to a suitable room, and the patient's risk assessment was not updated to reflect the incident. The provider did not consider the potential risk to other patients or the ward environment because of this incident.
- Staff did not carry out comprehensive searches of patients and their property prior to them re-entering

Enforcement actions

the ward after periods of leave. We found on Fenwick ward, staff were present when a patient purchased and then stored, in their bedroom, a hand held games console which had internet access. This contravened a condition imposed by the Ministry of Justice, which stated that the patient should not have internet access. When this breach of condition was identified staff failed to carry out an internal investigation in to this incident. They did not notify the Ministry of Justice and commissioners as required for this type of incident.

- We identified poor clinical practice and risk management in relation to the care of patients in seclusion. Staff did not adhere to safety procedures documented in patients' care plans. On Robinson ward, a care plan for a patient in long term seclusion stipulated three staff were required to open the door to the seclusion room and for the patient to be seated at the back of the room before staff opened the door or entered. We observed on three occasions, staff, including the nurse manager, opening the door alone or with only one other member of staff present. They did not ensure the patient was sitting at the back of the room before opening the door. This posed a risk to the patient because there was not enough staff to safely manage the patient and to staff if the patient became agitated. The nurse manager sustained facial injuries the week of the inspection from the same patient in seclusion.
- Staff on Fenwick and Robinson wards did not know how to operate the seclusion room's intercom system to speak with patients. This meant staff could not effectively communicate with the patient. The intercom on Ferguson ward was not working.
- Staff showed a lack of awareness about seclusion and long term segregation. Staff used inconsistent terminology in patient's records when referring to seclusion, they referred to extra care, enhanced care, and medical seclusion. Staff were not clear what these terms meant and what the difference was between them. Enhanced care and medical seclusion are not recognised terms in the Mental Health Act code of practice. The inconsistency posed a risk to patients because staff may not understand exactly

Enforcement actions

what constituted seclusion and not record what was required to treat a patient in a safe way, to meet the requirements of the Mental Health Act code of practice.

- On Fairbairn ward, we found three empty portable oxygen cylinders which reduced one patient's ability to have authorised leave off the ward. This also posed a risk if the patient needed emergency oxygen and staff did not realise the cylinders were empty and tried to use them to provide oxygen. On Robinson ward there was a container of out of date glucose monitoring strips in use for the care of patients with diabetes. Ferguson ward clinic room had a nebuliser with nine months out of date electrical safety testing, this meant the equipment could have been faulty and had not been checked. The monitoring process for checking equipment had not identified these faults.
- The provider did not ensure that staff were trained in one type of restraint techniques. This issue was raised in the June 2016 inspection report. Only 56% of staff were trained in Management of Actual and Potential Aggression (MAPA). The remaining staff were trained in Prevention and Management of Aggression and Violence (PMAV) techniques. Staffing on each shift contained staff who were trained in either type. This meant staff used different techniques when dealing with violence which could result in injury to the patient or staff. The provider had not implemented effective interim measures to manage the risk whilst the remaining staff completed their MAPA training. A procedure was in place whereby staff were meant to check at the beginning of each shift who was trained in each type of technique, this did not happen in the handovers we attended. When staff came from other wards to assist in an incident staff did not know who was trained in which type of training. Across the whole organisation, 5% of staff had not yet received MAPA and had not attended PMAV training.

This was a breach of regulation 12.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The monitoring and governance processes were not operated effectively to ensure issues were identified in a timely manner.

- The provider had not addressed previous concerns identified in June 2016 about respecting the privacy and dignity of patients in seclusion, the monitors were visible to staff from the office and to patients on entering or leaving the adjacent low stimulus room.
- There was no effective leadership and managerial oversight of seclusion practices. The provider had introduced a seclusion pack, to record seclusion, three months before we inspected in May 2017, however staff did not complete these fully.
- We identified that retrospective entries had been made in a seclusion record on Robinson ward. The seclusion record showed the time the seclusion commenced. No further entries were made within the seclusion record for 10 hours. There was no record of who clinically made the decision for seclusion to cease, the last entry on the log was completed by a healthcare assistant, with no counter signature and no additional information on the electronic record.
- Handovers in forensic and rehabilitation services did not include all relevant information needed for staff. The provider did not ensure that the staff adhered to the handover process on all wards. We observed that staff did not effectively handover all patients' care; on Robinson ward night staff did not handover information to the day staff about the patient nursed in seclusion. If staff were late on shift then they were not provided with a handover.
- The provider had no oversight in regards to the documentation regarding individual patient's capacity assessments. We reviewed 70 care records; the records did not always document discussion around a patient's capacity.
- Records of ongoing physical healthcare monitoring were of poor quality in forensic, rehabilitation, and the psychiatric intensive care unit. Four out of the 13 records seen in forensic were for patients with long

This section is primarily information for the provider

Enforcement actions

term conditions. Records did not show ongoing monitoring of physical healthcare assessment or provision. Records of ongoing physical healthcare monitoring were not always present or were not sufficiently detailed. We identified an example of staff not adhering to wound care and infection control guidance linked to the patient's care and treatment plan on Ferguson ward. A patient on the intensive care unit had developed a pressure sore and following investigation it was concluded that staff had focussed on his mental health to the detriment of his physical health and should in the future adopt a more holistic approach.

- Whilst the provider had completed ligature risk audits which included action plans, they did not ensure that the identified action had timescales set for the work to be completed.
- The provider did not ensure that if agency staff were booked to cover vacancies they had the access to the electronic records to ensure that they could access patient records and the electronic prescribing system to administer medications.

This was a breach of regulation 17