St Andrew's Healthcare - Mens Service

Quality Report

Cliftonville House
Billing Road
Northampton
NN1 5DG
Tel: 01604 616000
Website: www.stah.org

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

Overall summary

We did not rate this service.

We carried out this inspection to check compliance following the warning notice issued after the focused inspection in May 2017.

We found the following areas the provider needs to improve:

- Seclusion records reviewed did not always include sufficient recording to demonstrate that all of the safeguards under the Mental Health Act code of practice had been met. Medical and nursing staff had not always completed reviews in line with the Mental Health Act Code of Practice. Staff had not always fully completed seclusion documentation.
- Managers were not supervising staff in line with the providers management supervision policy introduced in November 2017. Data provided by the service as of the 30 November 2017, evidenced a management supervision compliance rate of 20% overall for forensic and rehabilitation wards. Three wards reported compliance rates of 0%.

We found the following areas of good practice:

- Managers and staff ensured that wards were clean, maintained and well furnished.
- Staff had completed risk assessments for all patients and full physical health assessments for 95% of patients on admission. Patient records had evidence of ongoing physical health care.
- The provider had addressed the issue of staff being trained in two types of restraint technique. At the time of our visit, 91% of staff in the men's service had completed Management of Actual and Potential Aggression training.
- Staff demonstrated a good understanding of safeguarding practices. The provider reported that 94% of staff had completed level 1 and 2 safeguarding training. Staff were able to describe action they would take if they had safeguarding concerns.
- Governance and monitoring processes had improved. The service director and clinical director chaired weekly governance meetings with consultants, ward managers, multi-disciplinary leads, modern matron and compliance manager.

Summary of findings

Contents

St Andrew's Healthcare Northampton Men's Services

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

Summary of this inspection

Background to St Andrew's Healthcare - Mens Service

St Andrew's Healthcare Northampton has been registered with the CQC since 11 April 2011. The services have a registered manager and a controlled drugs accountable officer.

Northampton is a large site consisting of more than ten buildings, over 50 wards and has 659 beds. There are four locations registered at Northampton; adolescent services, men's services, women's services and acquired brain injury (neuropsychiatry) services.

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

The locations at St Andrew's Healthcare, Northampton have been inspected 21 times. The last inspection was in May 2017.

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.

We inspected men's services to check compliance with the warning notice issued following the focused inspection in May 2017.

The following services were visited on this inspection:

Forensic inpatient/secure wards:

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 15 beds for people with impaired hearing.

• Prichard ward is a medium secure ward with 15 beds.

All patients receiving treatment in this service are detained under the Mental Health Act (1983).

Long stay/rehabilitation mental health wards for working age adults:

We inspected:

• Ashby ward (previously Ferguson ward) provides support for up to 16 male patients in a locked rehabilitation environment.

• Church ward provides support for up to 10 male patients in a low secure environment.

• Fenwick ward provides support for up to 10 male patients in a low secure environment.

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

We inspected:

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

We are planning to conduct a comprehensive inspection of men's services in March 2018.

Our inspection team

Team leader: Margaret Henderson

The team that inspected the services comprised one CQC inspection manager, two CQC inspectors, three specialist advisors; two nurses and a consultant psychiatrist and an expert by experience, who had personal experience of using or caring for someone who uses the type of services we were inspecting.

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 provider.

Summary of this inspection

Why we carried out this inspection

We undertook this inspection to find out whether St Andrew's Healthcare men's services were compliant following the warning notice issued after the focused inspection in May 2017.

When we last inspected the Northampton site in May 2017, the overall rating for this service was inadequate. We rated the safe and well-led key questions as inadequate for forensic services. We rated the safe and well-led key questions as inadequate for rehabilitation. We rated the safe key question as requires improvement for the psychiatric intensive care unit.

Following the inspection of St. Andrew's Healthcare, Northampton Men's service we found significant improvements were required and issued a Section 29 Warning Notice.

Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified in this service. These related to:-

Regulation 10 – dignity and respect;

- The provider did not ensure the privacy and dignity of patients in seclusion.

Regulation 12 – safe care and treatment;

- The provider did not ensure a safe and clean environment for patients. Wards were visibly dirty and staff did not adhere to infection control procedures.
- Risk management processes were not effective and staff failed to follow care plans for patients requiring specialist care.
- Handovers in forensic and rehabilitation services did not include all relevant information needed for staff.
- Staff did not adhere to conditions imposed by the Ministry of Justice.
- We identified poor clinical practice and risk management in relation to the care of patients in seclusion.
- Staff showed a lack of awareness about seclusion and long term segregation.
- We found poorly maintained medical equipment.
- Staff had poor levels of understanding of safeguarding practices and procedures.
- The provider did not ensure that staff were trained in a single type of restraint technique.

Regulation 17 – 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.
- There was no effective leadership and managerial oversight of seclusion practices, we identified that retrospective entries had been made in a seclusion record.
- The provider had no oversight in regards to the documentation regarding individual patient's capacity assessments.
- Records of ongoing physical healthcare monitoring were of poor quality in forensic, rehabilitation and the psychiatric intensive care unit.
- 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 agency staff had access to the electronic records.

We found that the provider had addressed most of the issues. We have identified the issues which remain later in this report.

How we carried out this inspection

We have reported in four of the five key questions; safe, effective, responsive and well led. As this was a focused inspection, we looked at specific key lines of enquiry in line with actions required from the warning notice. Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report.

Summary of this inspection

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

During the inspection visit, the inspection team:

- visited six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 11 patients who were using the service;
- interviewed the ward managers for three of the wards;
- spoke with 19 other staff members; including doctors, nurses, healthcare assistants, technical instructors, administrators and domestic staff;
- looked at 39 care and treatment records of patients, including seclusion records and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with eleven patients during our visit.

- All patients spoken with told us they felt safe and that the wards were clean and well maintained.
- Patients told us that regular staff treated them with respect and were polite, but that some bank and agency staff were disrespectful and lacked compassion.
- Patients told us that there were low numbers of permanent staff and high use of bank and agency staff.
- Three patients told us that the food was not good; it was sometimes cold and portion sizes were small.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate this key question.

We found the following areas the provider needs to improve:

- Seclusion records reviewed did not always include sufficient recording to demonstrate that all of the safeguards under the Mental Health Act code of practice had been met. We reviewed nine individual patient seclusion records. Doctors had not completed medical reviews in line with the Mental Health Act Code of Practice in seven records. Nurses had not completed reviews required in line with the code in two records. Staff had not fully completed seclusion documentation in four records.
- Staff had not included any detailed information in risk assessments for some patients on Ashby ward.
- The seclusion ensuite room door on Fairbairn (specialist deaf service) made a click to indicate that the door was unlocked when in use by a patient, this was ineffective as deaf patients could not hear the click. The clocks in Church and Fenwick seclusion rooms were displaying the wrong time. We pointed these issues out to the provider who said they would rectify them immediately.
- The ligature audit action plan for Heygate had one action point. This action did not have a timescale and it was not clear if it staff had completed it.

We found the following areas of good practice:

- Managers and staff ensured that wards were clean, maintained and well furnished. Staff were able to describe the procedures they followed in relation to infection control. There was an infection control link nurse. There was a noticeboard in the staff office with information relating to infection control.
- Staff had completed detailed risk assessments for all patients and reviewed these regularly, with the exception of Ashby ward where some risk assessments consisted of ticked boxes. Staff had completed positive behavioural support plans for all patients reviewed. These included up to date risks and interventions required.
- The provider had addressed the issue of staff being trained in two types of restraint technique. At the time of our visit, 91% of staff in the men's service had completed Management of Actual and Potential Aggression training.

Summary of this inspection

- Staff understanding of seclusion and long-term segregation had improved. There was a new seclusion policy in place, which clearly defined seclusion. Staff we spoke with demonstrated an understanding of what constituted seclusion.
- Staff demonstrated a good understanding of safeguarding practices. The provider reported that 94% of staff had completed level 1 and 2 safeguarding training. Staff were able to describe the action they would take if they had safeguarding concerns.

Are services effective?

We did not rate this key question.

We found the following areas of good practice:

- Staff met the physical healthcare needs of patients. We reviewed 39 care and treatment plans. Staff had completed full physical health assessments for 95% of patients on admission and all patient records had evidence of on going physical health care. Staff had completed care plans for patients with specific long-term health conditions, such as diabetes and asthma.
- Handovers included all relevant information needed for staff. The provider had implemented a new handover process. Staff completed a handover document with set headings to ensure all aspects of a patients care were included. Staff spoken with told us that the new handover process ensured they had relevant and up to date information before they started their shift.
- The provider had ensured that agency staff had access to the electronic systems for patient records and electronic prescribing. The service would provide agency staff with a temporary log in to use when on shift.

Are services responsive?

We did not rate this key question.

We found the following areas of good practice:

- The provider had moved the televisions screens displaying closed circuit television footage for the seclusion bedroom and bathroom. The provider had relocated screens to the observation room and only the member of staff allocated to observe the patient in seclusion could see the screens.

Are services well-led?

We did not rate this key question.

We found the following areas the provider needs to improve:

Summary of this inspection

- Managers were not supervising staff in line with the providers management supervision policy introduced in November 2017. Data provided by the service as of the 30 November 2017, evidenced a management supervision compliance rate of 20% overall for forensic and rehabilitation wards. Three wards reported compliance rates of 0%.

We found the following areas of good practice:

- Governance and monitoring processes had improved. The service director and clinical director chaired weekly governance meetings with consultants, ward managers, multi-disciplinary leads, the modern matron and compliance manager. The provider had implemented a weekly dashboard across the men's service, which included data for agency staff use, incidents, safeguarding, seclusion and restraint for each ward.
- The provider had implemented a new approach to managing ligature risks. This consisted of a ward based assessment, auditing patients' positive behaviour support plans against the most recent risk assessment and checking that ligature risks are included in patients care plans.
- Staff reported positive morale and spoke highly of the new senior management team. Managers told us that senior staff were giving them more control, whereas previously they had to ask permission to get anything done. They also told us that there had been a reduction in micro management from the executive team and that senior managers were devolving decision making to ward level.

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

Safe	
Effective	

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

Safe and clean environment

We reviewed the ligature audit and action plan. Managers had completed the audit on 11 April 2017, reviewed and updated it on 30 May 2017 and 29 December 2017. The action plan had one action point. This action did not have a timescale and it was not clear if managers had completed the action. We reviewed patients individual risk assessments, which included, where relevant a section on ligature risks.

Assessing and managing risk to patients and staff

The provider reported that 91% of staff had completed Management of Actual and Potential Aggression training.

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

(for example, treatment is effective)

Assessment of needs and planning of care

Staff were assessing patient needs and planning their care. We reviewed five care and treatment records for patients, focusing on physical health assessments and ongoing monitoring and care. All patients had received a full physical health assessment on admission and all had evidence of ongoing physical health care in their records.

The provider had ensured that agency staff had access to the electronic systems for patient records and electronic prescribing. The service provided agency staff with a temporary log in to use when on shift.

Forensic inpatient/secure wards

Safe	
Effective	
Responsive	
Well-led	

Are forensic inpatient/secure wards safe?

Safe and clean environment

Managers and the health and safety lead had completed ligature audits within the last six months. Managers had completed required actions or they were within target date for completion.

Staff were able to communicate with patients in seclusion and staff demonstrated use of the intercom systems. Staff showed us that the seclusion ensuite room door on Fairbairn (specialist deaf service) made a click to indicate that the door was unlocked when in use by a patient, this was ineffective as deaf patients could not hear the click. We pointed this out to the provider who said they would rectify this, although they did not provide a time scale for this to be done.

Safe staffing

Staffing levels had improved. The provider used bureau (St Andrew's bank staff) and agency staff to fill vacant shifts. However, a number of qualified shifts remained unfilled.

The provider reported fill rates of 84% for planned qualified shifts for the period 1 September 2017 to 5 January 2018. Prichard had overfilled their qualified shifts at 113%. Robinson reported the lowest fill rate for qualified staff at 63% and Fairbairn reported 75%. Across the service, 5% of shifts ran with less than two qualified staff on duty. Fairbairn reported 7% of shifts ran with under two qualified staff, Robinson 6% and Prichard 3%. The service had overfilled non-qualified staff shifts.

Assessing and managing risk to patients and staff

Staff were assessing and managing risks to patients and staff. We reviewed ten patient care and treatment records. Staff had completed risk assessments for all patients and reviewed these regularly. Staff had completed positive behavioural support plans for all patients reviewed. These included up to date risks and interventions required.

The provider reported that 91% of staff had completed Management of Actual and Potential Aggression training. Staff spoken with told us that they had completed this training.

Staff demonstrated understanding of seclusion and long-term segregation. There was a new seclusion policy in place, which clearly defined seclusion. Staff spoken with demonstrated an understanding of what constituted seclusion. The provider had updated the policy to include terminology in line with the Mental Health Act code of practice. The provider had facilitated road shows for staff to improve their awareness of seclusion and long-term segregation.

Staff had completed seclusion care plans and were able to describe how they managed risks using care plans, including positive behaviour support plans.

Staff were not always completing seclusion documentation. We reviewed the seclusion register on Robinson and Prichard wards. Staff had made 21 entries for Robinson ward since August 2017. Staff had completed these correctly. On Prichard, staff had made 28 entries since May 2017. Three of these entries did not include the date and time that seclusion was terminated or the duration of the seclusion. A nurse had not signed one entry. We reviewed nine individual patient seclusion records. Staff had not fully completed seclusion documentation in four records. This included incomplete food and fluid charts and seclusion checklists. Staff had completed the required observations in all records.

Medical and nursing staff were not completing reviews in line with the Mental Health Act Code of Practice. Doctors had not completed all required medical reviews in seven records. Nurses had not completed all required reviews in two records.

Forensic inpatient/secure wards

We found no evidence of staff making retrospective entries on this visit. The provider had fully investigated the incident in May 2017 regarding retrospective entries being made in a seclusion record. The provider had taken action to mitigate against this happening again.

Staff demonstrated a good understanding of safeguarding practices. The provider reported that 94% of staff had completed level 1 and 2 safeguarding training. Staff were able to describe the action they would take if they had safeguarding concerns. This included what they would do and where they would get support at the weekend. Managers displayed posters with information about the providers safeguarding leads, at an organisational and local ward level.

Staff were checking and maintaining medical equipment. Staff had ensured that all oxygen cylinders on Fairbairn ward were full. On Robinson ward, the glucose monitoring strips were all in date. The provider had introduced a secondary checking system to ensure staff were completing clinical checks as required.

Are forensic inpatient/secure wards effective?
(for example, treatment is effective)

Assessment of needs and planning of care

Staff were assessing patient needs and planning their care. We reviewed 17 care and treatment records for patients, focusing on physical health assessments and ongoing monitoring and care. Staff had completed full physical health assessments for all patients on admission and all had evidence of ongoing physical health care in their records. Staff had completed care plans for patients with specific long-term health conditions, such as diabetes and asthma.

The provider had ensured that agency staff had access to the electronic systems for patient records and electronic prescribing. The service would provide agency staff with a temporary log in to use when on shift.

Multi-disciplinary and inter-agency team work

The provider had implemented a new handover process. Staff completed a handover document with set headings to ensure all aspects of a patients care were included. Staff used this document in handover to the oncoming shift. The document was stored in a folder and was accessible to all staff. We reviewed the handover records for the three wards. The records were complete and up to date for all patients. Staff we spoke with told us that the new handover process ensured they had relevant and up to date information before they started their shift.

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

The facilities promote recovery, comfort, dignity and confidentiality

The provider had moved the televisions screens displaying closed circuit television footage for the seclusion bedroom and bathroom. The provider had relocated screens to the observation room and only the member of staff allocated to observe the patient in seclusion could see the screens.

Are forensic inpatient/secure wards well-led?

Good governance

Governance and monitoring processes had improved. The service director and clinical director chaired weekly governance meetings with consultants, ward managers, multi-disciplinary leads, modern matron and compliance manager. The meeting looked at current and likely issues; staffing levels; incidents; seclusions; segregation; compliance issues; cleanliness; infection control and housekeeping for each ward.

The provider had re-established a monthly patient safety meeting looking at serious incidents and lessons learned; restrictive practice; safeguarding issues; medication errors and physical health.

The provider had addressed the issue with seclusion monitors.

The number of unfilled shifts had reduced and staff turnover had reduced to an average of 15% across men's services, although the provider advised that work was still ongoing to improve staffing levels.

Managers were not supervising staff in line with the providers management supervision policy introduced in

November 2017. Data provided by the service evidenced a management supervision compliance rate of 7% overall as of 30 November 2017. Robinson reported the highest rate at 20%, whilst Prichard and Fairbairn had reported 0%. Following the inspection we were provided with data that evidenced a compliance rate of 79% across the men's service, as of 31 January 2018.

The provider had implemented a weekly dashboard report across the men's service, which included data for agency staff use, incidents, safeguarding, seclusion and restraint for each ward. The provider completed weekly audits of seclusion paperwork, with feedback given to nurse managers on the spot. The provider had also introduced bi monthly audits of patient care plans to ensure staff completed capacity assessments as required.

The provider had implemented a new approach to managing ligature risks. This consisted of a ward based assessment, auditing patients' positive behaviour support plans against the most recent risk assessment and checking that ligature risks are included in patients care plans.

Leadership, morale and staff engagement

We found that the provider had taken an approach to be as visible as possible, with senior managers attending staff handovers once a fortnight to improve contact with frontline staff. We asked six staff if they had experienced any bullying. One reported that they were aware of a colleague that had been bullied, the others reported positive morale and spoke highly of the new senior management team.

Managers told us that senior staff were now giving them more control, whereas previously they had to ask permission to get anything done. They also told us that there had been a reduction in micro management from the executive team and that senior managers were devolving decision making to ward level.

Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Responsive	
Well-led	

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

Safe and clean environment

The provider had relocated Ferguson ward to Ashby ward. We found managers had completed up to date ligature audits on all wards. Managers had identified and mitigated against all ligature risks. For example, there were ligature risks identified in the assisted bathroom. Staff mitigated these risks by locking the bathroom and patients requested access, with staff supervision if required.

Church and Fenwick wards had seclusion rooms. Staff were able to communicate with patients in seclusion. Staff demonstrated use of the intercom systems during this visit.

The clocks in Church and Fenwick seclusion rooms were displaying the wrong time. We pointed this out to the provider who said they would rectify this.

The wards were clean, maintained and well furnished. Following a deep clean of all wards, the provider had introduced a monthly audit of the wards, carried out by someone from another team to increase objectivity. There was an infection control link nurse. There was a noticeboard in the staff office with information relating to infection control.

Safe staffing

Staffing levels had improved. The provider used bureau (St Andrew's bank staff) and agency staff to fill vacant shifts. However, a number of qualified shifts remained unfilled.

The provider reported fill rates of 100% for planned qualified shifts for the period 1 September 2017 to 5 January 2018. Fenwick had overfilled their qualified shifts at 121%. Church reported the lowest fill rate for qualified staff at 82% and Ashby reported 98%. Across the service, 10% of shifts ran with less than two qualified staff on duty. These were all on Ashby ward. Ashby and Fenwick had overfilled non-qualified staff shifts.

Assessing and managing risk to patients and staff

Staff were assessing and managing risks to patients and staff. Staff were able to describe the procedures they followed in relation to infection control for patients. We checked the care records of the patient who required specialist wound care. Staff had followed his treatment plan and his wound had healed.

Staff were completing risk assessments for patients. We reviewed ten patient care and treatment records. Staff had completed risk assessments for all patients and reviewed these regularly. However, we found the level of detail in risk assessments to be variable with some risk assessments completed by ticking boxes. Staff had completed positive behavioural support plans for all patients reviewed. These included up to date risks and interventions required.

Staff were following care plans and risk assessments for patients subject to Ministry of Justice restrictions.

The provider had a search policy that stated staff must search all patients prior to them re-entering the ward after periods of leave. We observed staff adhering to this policy during our visit.

The provider reported that 91% of staff had completed Management of Actual and Potential Aggression training. Staff spoken with told us that they had completed this training.

Staff demonstrated understanding of seclusion and long-term segregation. There was a new seclusion policy in place, which clearly defined seclusion. Staff spoken with demonstrated an understanding of what constituted seclusion. The provider had updated the policy to include terminology in line with the Mental Health Act code of

Long stay/rehabilitation mental health wards for working age adults

practice. The provider had facilitated road shows for staff to improve their awareness of seclusion and long-term segregation. Ashby did not have a seclusion room and Church and Fenwick rarely used seclusion.

Staff were checking and maintaining medical equipment. Ashby did not have any nebulisers. The provider had introduced a secondary checking system to ensure staff were completing clinical checks as required.

Reporting incidents and learning from when things go wrong

The provider had improved their oversight of incidents using a quality audit tool and weekly governance meetings. The weekly governance meetings check that staff have notified the right people in relation to any incident, for example Ministry of Justice.

Are long stay/rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Assessment of needs and planning of care

Staff were assessing patient needs and planning their care. We reviewed 17 care and treatment records for patients, focusing on physical health assessments and ongoing monitoring and care. Staff had completed full physical health assessments for 15 patients on admission and all had evidence of ongoing physical health care in their records. Staff had completed care plans for patients with specific long-term health conditions, such as leg ulcers and asthma.

The provider had ensured that agency staff had access to the electronic systems for patient records and electronic prescribing. The service would provide agency staff with a temporary log in to use when on shift.

Multi-disciplinary and inter-agency team work

The provider had implemented a new handover process. Staff completed a handover document with set headings to ensure all aspects of a patients care were included. Staff used this document in handover to the oncoming shift. The document was stored in a folder and was accessible to all staff. We reviewed the handover records for the three wards. The records were complete and up to date for all patients. Staff spoken with told us that the new handover process ensured they had relevant and up to date information before they started their shift.

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

The facilities promote recovery, comfort, dignity and confidentiality

The provider had moved the televisions screens displaying closed circuit television footage for the seclusion bedroom and bathroom. The provider had been relocated the screens to the observation room and only the member of staff allocated to observe the patient in seclusion could see the screens.

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

Good governance

Governance and monitoring processes had improved. The service director and clinical director chaired weekly governance meetings with consultants, ward managers, multi-disciplinary leads, modern matron and compliance manager. The meeting looked at current and likely issues; staffing levels; incidents; seclusions; segregation; compliance issues; cleanliness; infection control and housekeeping for each ward.

The provider had re-established a monthly patient safety meeting looking at serious incidents and lessons learned; restrictive practice; safeguarding issues; medication errors and physical health.

The provider had addressed the issue with seclusion monitors.

The number of unfilled shifts had reduced and staff turnover had reduced to an average of 15% across men's services, although the provider advised that work was still ongoing to improve staffing levels.

Long stay/rehabilitation mental health wards for working age adults

Managers were not supervising staff in line with the providers management supervision policy introduced in November 2017. Data provided by the service evidenced a management supervision compliance rate of 32% overall as of 30 November 2017. Fenwick reported the highest rate at 60%, whilst Church reported 47% and Ashby reported 0%. Following the inspection we were provided with data that evidenced a compliance rate of 79% across the men's service as of 31 January 2018.

The provider had implemented a weekly dashboard across the men's service, which included data for agency staff use, incidents, safeguarding, seclusion and restraint for each ward. The provider had introduced weekly audits of seclusion paperwork, with feedback given to nurse managers on the spot. The provider had also introduced bi monthly audits of patient care plans to ensure staff completed capacity assessments as required.

The provider had implemented a new approach to managing ligature risks. This consisted of a ward based assessment, auditing patients' positive behaviour support plans against the most recent risk assessment and checking that ligature risks are included in patients care plans.

Leadership, morale and staff engagement

The provider had taken an approach to be as visible as possible, with senior managers attending staff handovers once a fortnight to improve contact with frontline staff. Staff spoken with did not report any bullying and were mostly positive about working on the wards.

Managers told us that senior staff had given them more control, whereas previously they had to ask permission to get anything done. They also told us that there had been a reduction in micro management from the executive team and that senior managers were devolving decision making to ward level.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure medical and nursing staff complete seclusion reviews as required in line with the Mental Health Act code of practice and that staff fully complete seclusion documentation.
- The provider must ensure that staff receive management supervision in line with their policy.

Action the provider SHOULD take to improve

- The provider should ensure that qualified staff shifts are filled.
- The provider should ensure that seclusion facilities meet the specialist needs of patients and that seclusion clocks display the correct time.
- The provider should ensure that staff complete detailed risk assessments for all patients.
- The provider should ensure that all actions identified on ligature audits include a timescale for actions to be completed.

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 Medical and nursing reviews were not being completed as required in line with the Mental Health Act code of practice. Staff were not always fully completing seclusion documentation. 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 18 HSCA (RA) Regulations 2014 Staffing Staff were not receiving management supervision in line with the providers policy. The forensic and rehabilitation services reported a compliance rate of 20%. Three wards reported compliance rates of 0%. This was a breach of Regulation 18.