# St Andrew's Healthcare - Womens Service

## Quality Report

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

## Ratings

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

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

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

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

# 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 as good because:

- Care plans were comprehensive and holistic, and contained a full range of patients' needs. Staff completed patients risk assessments in a timely manner and updated these after incidents.
- Wards had adequate space for delivering care and treatment of patients, with appropriate seclusion rooms, low stimulus rooms, and extra care suites for patient use. All patient bedrooms had ensuite facilities.
- Managers ensured that staff had received training in safeguarding and made appropriate referrals.
- A range of psychological therapies recommended by the national institute for health and care excellence was available for patients.
- Patients had access to independent mental health advocacy.
- St. Andrews Hospital had its own physical healthcare team who saw patients on the wards.
- Staff cared for patients who presented with behaviour that challenged. Managers and staff worked extra shifts to support the wards, which showed resilience and commitment toward delivering patient care.
- Wards had family friendly visiting rooms along with policies and procedures for children visiting.
- Staff received regular supervision and had received annual appraisal.
- Senior staff monitored incidents and discussed outcomes and learning from them in team meetings.
- There were robust systems in place for reporting and investigating incidents and complaints. 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.

However:

- Staffing numbers did not meet establishment levels. There were high numbers of vacant posts. Whilst managers booked agency staff to cover vacancies at short notice this resulted in staff who were often unknown and unfamiliar with the wards and the patients. In particular high numbers of registered agency nurses had been booked for night duty, many of whom were male, and not known to the female patients. Agency staff did not have access to all of the systems, adding additional responsibilities onto the permanent staff.
- The provider had not addressed the issue identified in the June 2016 inspection whereby staff were trained in two types of managing aggression and restraint. Fifty one percent of staff had received Management of Actual and Potential Aggression (MAPA) training and 47% of staff were trained in Prevention and Management of Aggression and Violence (PMAV). The remaining staff (2%) were out of date with training. This posed a risk to staff and patients if staff were following two different approaches.
- Staff were unclear about the definitions and terminology relating to de-escalation, restraint, seclusion, segregation and extra care. Policies for seclusion, long term segregation and enhanced support were confusing and the long term segregation policy did not meet the Mental Health Act code of practice in respect of review requirements. Staff did not fully complete seclusion records, including physical healthcare monitoring during an episode of seclusion.
- There was insufficient medical cover for overnight on call and emergencies.
- Managers and medical staff told us that in recent months they had felt pressurised into accepting patients, who in their clinical opinion, were not suitable. Medical staff told us clinical decisions were made at a senior level without any evidence based rationale or consultation at a clinical level.
- Feedback from focus groups and information received through CQC also reported a bullying culture in some parts of the organisation. However, the provider does

# Summary of findings

have various avenues through which staff can raise grievances and concerns. There were no formally reported cases of bullying or harassment when we visited the service.

- Seacole ward had outstanding maintenance issues. The heating was not working properly. We had identified a similar issue in the June 2016 inspection. Staff and patients reported a smell of sewerage in the ensuite bathrooms of some rooms. Sunley ward was not clean, bed linen was stained and smelly, and dirty linen was stored with clean linen.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Forensic inpatient/ secure wards** | Good  | • Seacole is a medium secure ward.<br>• Stowe is a medium secure ward.<br>• Sunley is a medium secure ward.<br>• Elgar is a low secure ward.<br>• Spencer South is a low secure ward.<br>• Sinclair is a low secure ward. |
| **Long stay/ rehabilitation mental health wards for working-age adults** | Good  | • Thornton is a locked rehabilitation ward.<br>• Hereward Wake is a locked rehabilitation ward.<br>• Spring Hill is a locked rehabilitation ward. |
| **Wards for people with learning disabilities or autism** | Good  | • Spencer North is a low secure ward.<br>• Sitwell is a medium secure ward. |

# Summary of findings

## Contents

Good

**Women's services St Andrew's Healthcare**

**Services we looked at**

Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults; Wards for people with learning disabilities or autism

# Summary of this inspection

## Background to St Andrew's Healthcare - Womens 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 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.

The locations at St Andrew's Healthcare Northampton have been inspected 20 times. The last inspection was in February 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.

The following services were visited:

**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. All wards are single sex and follow care pathways as patient's progress with their recovery.

The female pathway includes both medium and low secure wards. We inspected the following wards:

• Seacole Ward is a medium secure ward with 15 beds.

• Sunley ward is a medium secure ward with 14 beds.

• Elgar ward is a low secure ward with 12 beds for females over the age of 45 years.

• Spencer South is a low secure ward with 14 beds.

• Sinclair ward is a low secure ward with 15 beds.

• Stowe Ward is a medium secure ward with 14 beds, however, we were unable to visit this ward, because it was in isolation due an outbreak of diarrhoea and vomiting.

**Long stay / rehabilitation wards for working age adults:**

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

• Thornton ward provides support for up to 15 female patients in a locked rehabilitation environment.

• Hereward Wake provides support for up to 12 female patients in a locked rehabilitation environment.

• Spring Hill House is a locked unit which provides specialist support to female patients diagnosed with borderline personality disorder. The ward has 23 beds. Spring Hill House is a progressive environment that offers different types of accommodation and observation based on patient risk. Patients are able to progress to Spring Hill House from Seacole and Spencer South wards, which are medium and low secure wards at St Andrew's Healthcare Northampton. Patients can be admitted directly to Spring Hill House. Pre-discharge work takes place to integrate patients back in to the community.

**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:

• Sitwell ward, a 14 bed medium secure service for women with learning disabilities and /or autistic spectrum conditions.

• Spencer North ward, a 15 bed low secure service for women with learning disabilities and/or autistic spectrum conditions.

The learning disabilities (LD) pathway provides care and treatment for adults with mild to moderate learning disabilities and other neuro-developmental disorders who have offended or display behaviour which

# Summary of this inspection

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.

This was a focused announced 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 two CQC inspection managers, five CQC inspectors, eight specialist nurse advisors and six 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 women'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. The safe and effective key questions were rated as requires improvement. The caring, responsive and well led key questions were rated as good.

The forensic inpatient/ secure wards and long stay/ rehabilitation mental health wards for working-age adults were rated as requires improvement overall.

The wards for people with learning disabilities or autism were rated as good. However, we re-inspected this service in February 2017 owing to concerns raised around the use of restraint. We decided to inspect all key questions in learning disabilities service 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 and 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 the air exchange system is working efficiently.

• 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 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

# Summary of this inspection

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. 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 ten wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 58 patients who were using the service
- spoke with eight carers
- interviewed the nurse manager or acting manager for each of the wards
- spoke with 59 other staff members; including doctors, nurses, healthcare assistants, clinical and forensic psychologists, trainee psychologists
- looked at 47 care and treatment records of patients
- spoke with an independent advocate
- attended and observed two hand-over meetings, three multidisciplinary meetings, and observed one patient social activity
- collected feedback from 36 patients using comment cards
- received feedback about the service from ten care co-ordinators or commissioners
- carried out a specific check of the medication management on three wards
- 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 58 patients using the service, eight carers of people using the service and reviewed feedback from 36 comment cards completed by patients.

- Some patients said they felt concerned that there was not enough staff to deal with incidents when they occurred. Three patients were concerned for staff safety.
- Patients and carers told us staffing and inappropriate referrals were the biggest problems on the wards. Four patients told us they felt unsafe on the wards because of some very agitated and aggressive patients they felt should not have been admitted to that ward. Patients told us when staff were engaged in managing very complex patients, other patients on the ward were grouped together so they could be observed by any remaining staff.
- Three patients told us of incidents whereby they had been bullied and attacked by other patients and despite having made complaints to ward staff they had not received adequate reassurance a similar thing would not happen again.
- Patients said there were often too few staff to allow section 17 leave to take place, even for escorts into the courtyard area for fresh air. Patients told us if staff cancelled their leave activities they only offered indoor board games or craft activities instead.
- Eight patients told us how the ward was staffed with a high number of unfamiliar male staff, particularly at night, which they found threatening.
- Patients told us they all have to go to bed at the same time. However, the provider advised that this is to protect patients from harm and to promote their wellbeing.
- Three patients said that since going to St Andrews, they felt they had developed coping skills and become better at managing themselves and their aggression, with the help from staff.
- Patients told us they were involved in their care plans and could describe the goals they were working towards. Patients said they had regular one to one time with staff.

# Summary of this inspection

- Patients were positive about the psychology team and the group work on offer.
- Most patients said the regular staff treated them with respect. However, on the learning disability wards four patients said staff could be snappy when they are under pressure and some staff were rude.
- Three patients said they felt encouraged to bring any ideas about the service to community meetings. They knew how to make a complaint.
- Patients and carers told us most regular staff members were approachable and friendly, and if they had time, nurse managers and clinical leads were often very helpful and knowledgeable.
- Patients told us how they had been involved in formulating their own risk management plans using a graded level of risk, and staff had empowered them to be more forthcoming when asking for some of their risk restrictions to be lifted. Patients and carers said the positive behavioural support approach to care planning was much better than the previous care planning process.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

Requires improvement 

We inspected this key question for forensic services and the learning disabilities service. We also identified some issues in other services that we did not plan to inspect in this key question.

We rated safe as requires improvement because:

- Staffing numbers did not meet establishment levels. The provider had high staff vacancy rates. The provider used unfamiliar bank and agency staff to fill vacant shifts. Staff told us they were moved between wards to meet patient need, although the provider advised that this was done to cover unforeseen events such as staff sickness or escorts.
- Nurse managers covered two wards, sometimes leaving nurse clinical leads to run the shifts. Junior staff reported this put more responsibility on to them as they had to step up to carry out nurse clinical lead tasks. Not all agency staff had access to all of the systems, adding additional responsibilities onto the permanent staff.
- Staffing levels at night were particularly low. There was often only one registered agency nurse on duty, with little or no knowledge of the ward or the patient's needs.
- There was insufficient medical cover for overnight on call and emergencies.
- Staff were trained in different methods to manage violence and aggression. Fifty one percent of staff had received Management of Actual and Potential Aggression (MAPA) training and 47% of staff were trained in Prevention and Management of Aggression and Violence (PMAV). The remaining staff (2%) were out of date with training. Due to low staffing levels managers could not be assured that there were enough trained staff on duty for each ward, or that these staff had enough experience.
- Staff were unclear about the definitions and terminology relating to de-escalation, restraint, seclusion, segregation and extra care. Policies for seclusion, long term segregation and enhanced support were confusing and the long term segregation policy did not meet the code of practice in respect of review requirements. For example, the long term segregation policy allows for the nurse in charge rather that an approved clinician to review the patient daily and allows for another division of the hospital (rather than an external hospital) to undertake the three monthly reviews. An approved clinician is a mental health professional approved by the Secretary of State to act as an approved clinician for the purposes of the Mental

# Summary of this inspection

Health Act.Terminology was used interchangeably throughout the policies. Many staff described patients as being in 'extra care' when in fact they were either secluded or in long term segregation.

- Staff did not fully complete seclusion records, including physical healthcare monitoring during an episode of seclusion.
- Seclusion records were difficult to follow. We could not identify the official start time of one seclusion episode and the end time was not completed. We reviewed a mixture of documents for seclusions in patient records, and could not locate some medical reviews for patients during seclusion.
- Seacole ward heating was not working properly. We found some areas of the ward were uncomfortably cold. Patients complained of sewage and smells coming from the waste pipe in some of the ensuite bathrooms. Staff had not cleaned the seclusion room after use the previous evening and the toilet was damaged.
- Sunley ward was not clean and the bedlinen was stained and smelly. Clean linen had been stored with dirty linen.
- On Seacole ward, managers had identified the door handles on the locked laundry cupboards as ligature risks, but two patients had unsupervised access to this room.
- We could not be sure that rapid tranquilisation was being used in accordance with national institute of health and care excellence guidance because records were incomplete.
- The area at Springhill House used daily by all patients did not provide adequate seating or dining space.

However:

- Managers had mitigated identified ligature points by using nursing observations and individual risk assessments. Staff had quick access to ligature cutters and pocket masks in different areas of the ward. Staff completed environmental risk assessments daily and kept accurate records.
- During our inspection, we were given information about which patients on the ward may be distressed to see us. Staff and managers were clear on how we should respond to patients in this situation. This demonstrated safe management for patients, visitors and staff and effective management of de-escalation.
- Staff completed the Short Dynamic Risk Scale (SDRS), which allowed staff to assess risks for patients with learning disabilities. Risk assessments were reviewed at the patient's monthly multidisciplinary team meetings.

# Summary of this inspection

- The provider had ongoing recruitment and retention programmes to attract new staff, and was supporting healthcare assistants to undertake nurse training.
- Staff completed patients risk assessments in a timely manner and updated these after incidents.
- Staff received training in safeguarding and made appropriate referrals.
- The provider had good medicines management processes and medication was stored and administered correctly.
- The provider had family friendly visiting rooms along with policies and procedures for children visiting.

## Are services effective?

Good

We inspected this key question for all services.

We rated effective as good because:

- Care plans were comprehensive and holistic, and contained a full range of patients' needs. Care records included positive behaviour support plans and my shared pathway. There was evidence in the care records that physical assessments had taken place at the time of admission and periodically thereafter.
- A range of psychological therapies recommended by the national institute for health and care excellence was available for patients. A psychology team, with learning disabilities expertise worked with patients' education and social needs. Interventions were adapted based on comprehensive assessments to meet the needs of the patient group.
- Staff involved individual patients in reviewing their good behaviours. They would identify patterns and score these behaviours, helping patients to build awareness of when good behaviours occur.
- Staff used recognised rating scales, for example health of the nation outcome scores and discussed these in multidisciplinary meetings.
- The multidisciplinary team worked well together for benefit of patients.
- Staff received regular supervision and had received annual appraisal.
- Patients had access to independent mental health advocacy.

However:

- There was not always sufficient numbers of skilled and experienced staff on duty to meet the complex and often specialised needs of patients. Managers and medical staff told

us that in recent months they had felt pressurised into accepting patients, which in their clinical opinion were not suitable for the ward environment or accepted establishment of nursing staff.
- Not all Mental Health Act paperwork had been scanned to the electronic record and not all patients had been given copies of their section 17 leave plans. We could not locate a clear contingency or crisis plan for staff to follow during a patients leave on the learning disability wards.
- Handover records were not always kept in a clear location for staff to review. Staff said they did not always record what is said when a handover took place and they were compromised when shifts were short staffed. Records did not show regular effective handovers took place or included handovers for external teams.

## 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 this key question or change the ratings for forensic and rehabilitation wards.

We only inspected this key question in learning disabilities.

We rated caring as good because:

- Across both learning disability wards, we observed different disciplines of staff to be caring, and engaging with patients. Staff were caring and respectful in their approach to patients and showed an understanding of individual need.
- Patients were involved in their care planning unless they had declined. Care plans evidenced that patient preferences had been included and were individualised. Care plans were available in easy read format.
- Patients were positive about the psychology team and the group work on offer. One patient explained some of the mindfulness skills they had put into practice and another said they were pleased they had learnt skills.
- Both learning disability wards had some challenging patients, managers and staff worked extra shifts to support the wards, which showed resilience and commitment toward delivering patient care.

However:

- Four patients on the learning disability wards said staff could be snappy when they are under pressure and some staff were rude.

# Summary of this inspection

## Are services responsive?

Good

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

We only inspected this key question in learning disabilities.

We rated responsive as good because:

- The provider had investigated complaints and learnt lessons from them and had apologised when required in line with the Duty of candour.
- There was a full range of rooms available within the hospital. Patients from both learning disabilities wards could attend the gym, art room and separate kitchen if they wished to engage in activities and learn to cook.
- Spencer North ward had a separate lounge where patients could watch a film or TV. There was a dedicated visitors' room off the wards.
- There was a chaplaincy service and access to spiritual leaders for other faiths.
- Sitwell had a patient admission that was unsuitable for that mental health ward. However, we were advised that a more suitable placement was being sought and that Sitwell was the best place for the patient whilst this was being arranged.

## Are services well-led?

Good

We inspected this key question for all services.

We rated well-led as good because:

- Nurse managers told us their line managers and service directors were supportive.
- 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 were robust systems in place for reporting and investigating incidents and complaints. Managers fed back the outcomes and findings from these investigations to staff through team meetings and communication. Staff learned from incidents, complaints and service user feedback.
- Multidisciplinary teams worked well together across all wards, for the benefit of patients.
- All staff we spoke with were aware of their duty to be open and honest with patients when things went wrong. We saw examples where staff had explained to patients when something had gone wrong.

# Summary of this inspection

- Managers ensured that staff had access to regular clinical supervision and yearly appraisals.
- The provider used key performance indicators and other indicators to gauge the performance of the team. The measures were in an accessible format and used by the staff team who developed action plans when there were issues.
- Staff told us that there were opportunities available for developing leadership skills within St Andrews Healthcare.

However:

- During the last comprehensive inspection in July 2016, some staff said senior management do not attend the wards and they were unfamiliar with who the senior team were. During this inspection, some staff still did not know who some of the hospitals most senior managers were, and felt they were not visible on the wards. Other staff told us they no longer knew who the most senior managers were as there had been so many recent changes at that level.
- Nurse managers for all wards were responsible for two wards each. This meant clinical nurse leads had to act up in their absence putting additional pressure on less experienced and unqualified staff. Sitwell ward did not have a manager in post.
- Managers had not ensured that all mandatory training compliance rates were above 75%. Managers did not ensure they had the right levels of suitably trained staff on the wards to meet the individual needs of the patients.
- Staff we spoke with were unclear as to why some new procedures and paperwork had been introduced and how to implement them.
- Staff told us clinical decisions were made by managers at a senior level without any evidence-based rationale or consultation at a clinical level.
- Staff morale was not good on most wards, while most staff said they felt supported by their colleagues they felt they spent most time managing challenging behaviour rather than supporting patients in their recovery.
- Managers had not ensured that all restrictions in place were justified, regularly reviewed or based on individual patient needs.

# Detailed findings from this inspection

## Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- The hospital provided mandatory Mental Health Act 1983 training. Training records showed 76% of staff completed this as part of their induction as an online learning.
- A competent staff member, as authorised by the hospital managers examined mental Health Act papers upon a patient's admission. There were regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from these audits. The Mental Health Act administrators had a thorough scrutiny process using comprehensive checklists designed to highlight any errors or omissions. Despite this, a patient had been illegally detained but the provider was taking action to address this.
- Staff generally completed Mental Health Act paperwork correctly. Staff stored original Mental Health Act paperwork securely in the Mental Health Act office and scanned documents into the electronic patient records for staff reference. However, we found staff had not scanned some paperwork. This meant that staff on wards might not have easy access to these documents, when needed.
- Staff knew who they could seek advice from regarding the Mental Health Act. However, from records we reviewed staff were not always clear about how or when to continue to record and update patients capacity.
- Policies for seclusion long-term segregation and enhanced support were confusing and the long-term segregation policy did not meet the code of practice in respect of review requirements. For example, the long-term segregation policy allows for the nurse in charge rather that an approved clinician to review the patient daily and allows for another division of the hospital (rather than an external hospital) to undertake the three monthly reviews. Terminology was used interchangeably throughout the policies. 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.
- Extra care is not a concept set out in the code of practice – the code states that "If a patient is confined in any way that meets the definition they have been secluded and the use of any local or alternative terms (such as 'therapeutic isolation') or the conditions of the immediate environment do not change the fact that the patient has been secluded." It is essential that they are afforded the procedural safeguards of the Code. The hospital has no policy for extra care. Therefore, there is no guidance for staff on how to manage this practice and there is no policy statement about what safeguards should be in place for the protection of patients. Consequently, we found some patients who were being managed in a restrictive way but their status was unclear and their rights were not being met.
- The seclusion recording pack implemented in March 2017 was found in few records. Staff told us that they were unclear about the use of this and had only received this just prior to the inspection.
- We saw clear records of section 17 leave granted to patients. Where patients had not had leave, explanations were given, such as the patient being unsettled or too unwell. Staff recorded the time of section 17 leave, recording an explanation of outcomes. We could not locate a clear contingency or crisis plan for staff to follow during a patients leave on the learning disability wards.
- Records showed staff kept a copy of patient consent to treatment and capacity requirements with medication charts.
- Patients across the hospital could access the Independent Mental Health Advocacy, (an independent advocate who is specially trained to support people to understand their rights under the Mental Health Act and participate in decisions about their care and treatment) by pressing a speed dial number available on the patient phone. Patients we spoke with told us they had used this service and knew how to access it.
- 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

# Detailed findings from this inspection

health advocacy involvement with patients in long term segregation. Although, we did find that weekly multidisciplinary reviews had been undertaken in the majority of cases.

- Staff told us they explained patients' legal status and rights under Section 132 of the Mental Health Act on admission, on renewal of detention and every six months as standard practice and we saw evidence of this in patient records. It was unclear when a patient refused their rights, when staff would revisit this. The electronic Section 132 form did not include the role of the Care Quality Commission in complaints about the Mental Health Act.
- The Mental Health Act administrators' co-ordinated hearings and tribunals for patients and automatic hearings on renewal of detention.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- Records showed 76% of staff had training in the Mental Capacity Act.
- Staff supported patients to make their own decisions where possible, they said they considered all patients to have capacity and understood the principles.
- For patients who might have impaired capacity, staff assessed and recorded capacity to consent appropriately. When the doctor had established a patient did lack capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture, and history.
- The multidisciplinary team discussed capacity assessments during ward rounds. Managers would circulate an updated feedback form to staff weekly. We saw patient note entries where staff discussed capacity with the patient. Care plans reflected patient views around medication, interventions and decisions.
- A policy on Mental Capacity Act including Deprivation of Liberty Safeguards was available to staff. The provider monitored adherence to the Mental Capacity Act through regular audits.
- There were no Deprivation of Liberty Safeguard applications made in the last six months.
- Staff knew where to get advice regarding Mental Capacity Act and Deprivation of Liberty Safeguards within the hospital.
- Staff we spoke with were unsure about the Mental Capacity Act definition of restraint, there was also confusion around the definitions of seclusion, long-term segregation, and extra care.

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Forensic inpatient/ secure wards** | Requires improvement | Good | Good | Good | Good | Good |
| **Long stay/ rehabilitation mental health wards for working age adults** | N/A | Good | Good | Good | Good | Good |
| **Wards for people with learning disabilities or autism** | Requires improvement | Good | Good | Good | Good | Good |
| **Overall** | Requires improvement | Good | Good | Good | Good | Good |

Good

# Forensic inpatient/secure wards

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

## Are forensic inpatient/secure wards safe?

Requires improvement

**Safe and clean environment**

- Staff could not observe all parts of the forensic wards due to its layout. There were blind spots in the bedroom areas of the wards. Staff managed these areas by using nursing observations and individual patients risk assessment.
- Managers completed ligature risk assessments for all six wards. However, we found two ligature risks in the laundry room of Seacole ward that managers had identified but not fully mitigated against. These were the door handles on the locked cupboards above the washing machine, with drying clothes nearby. While staff supervised most patients in this area, two patients had unescorted access to the room. The ligature risk assessment stated that no patients had unsupervised access to this room. We pointed this out to management at the time of the inspection.
- The six forensic wards were female only and therefore complied with guidance on same sex accommodation.
- Wards had fully equipped clinic rooms with accessible with accessible resuscitation equipment and emergency drugs. Staff checked these regularly to ensure medication was fully stocked, in date and equipment was working effectively. A pharmacy technician completed a clinic room audit every three months.
- Across all wards equipment was well maintained, testing stickers were visible and in date. Furniture was clean and comfortable.
- Wards had seclusion rooms that allowed clear observation by staff and two-way communication. They had toilet facilities and patients could see the clock clearly whilst using the room. However, the seclusion room on Seacole was not clean, the toilet was damaged from the last incident of seclusion, which occurred a few hours before the inspection. In addition to seclusion rooms, we saw rooms designed as de-escalation quiet rooms, and extra care suites.
- Whilst all wards appeared to be well maintained, clean, and tidy, patients had complained of sewage and smells coming from the waste pipe in some of the ensuite bathrooms on Seacole ward. We had identified this as an issue in the June 2016 inspection. A staff member confirmed that this had been a problem in the past but thought it had been fixed. On the day of the inspection, we did not witness this and we did not see any current reports or plans for work to be done.
- Sunley ward was not clean and bedlinen was stained and smelly. Clean linen had been stored with dirty linen.
- Patients and staff reported that the heating on Seacole was not working properly. We found some areas of the ward to be uncomfortably cold. While maintenance staff had carried some works out, the problem had not been fully resolved and there was no date for repairs to be completed.
- Environmental risk assessments were undertaken regularly.
- Across all wards equipment was well maintained, testing stickers were visible and in date. Furniture was clean and comfortable.
- The provider had family friendly visiting rooms along with policies and procedures for children visiting.
- Staff carried personal alarms for use in an emergency to summon help, and a nurse was allocated for health and

safety on each shift. The health and safety nurse carried out regular health and safety checks of the environment throughout the day and monitored the comings and goings of visitors to the wards.
- Staff adhered to infection control principles including handwashing.

**Safe staffing**

- The provider set the core staffing levels for the service. They had estimated the number and skill mix of staff required, based on the type of wards to be staffed, number of patients, and their observational needs.
- The established level of registered nurses across the service from 01 November 2016 to 31 January 2017 was 52.8 whole time equivalent (WTE). At time of the inspection, there were 26.4 WTE vacancies. The established level of unqualified nurses was 87.4 WTE. The service had 7.8 unqualified vacancies.
- The provider had high staff vacancy rates. The provider used bank and agency staff to fill vacant shifts. Staff told us they were often moved between wards to cover vacancies, and if this was not possible then wards worked short of staff.The provider advised that this was done to cover unforeseen events such as staff sickness or escorts.
- Between 1 November 2016 to 31 January 2017 bank and agency staff covered 2752 shifts due to sickness, absence or vacancies. However, 610 shifts had not been covered, which resulted in wards working below the numbers required to meet the needs of patients.
- Management were aware of the staffing issues, the provider had ongoing recruitment and retention programmes to attract new staff. The provider was supporting healthcare assistants to undertake nurse training through their 'Aspire' programme.
- Staff average sickness rate for period 16 February 2016 to 17 January 2017 was 3%.
- We reviewed staffing levels at night and found that they were particularly low. Sinclair ward employed only one registered nurse at night. This nurse was usually an agency nurse and often male. Several patients commented that the majority of night staff were males. Any close observations during the night were being carried out by male staff. This made some patients feel vulnerable. Patients told us that when they had needed to be restrained this had usually been done by male staff. Two patients also told us that when other staff had to be called in from another ward they also tended to be male. If there was only one member of qualified staff on duty it was difficult to take breaks. If it was an agency nurse they did not all have access to the prescribing system so staff from other wards had to assist in administering medicines. This could cause a delay.
- Bank and agency staff were not familiar with the ward processes and protocols, leaving inexperienced or unqualified staff feeling as though they were responsible for managing the ward. For example, during a morning shift handover we observed how the nurse in charge of the night shift, an agency nurse, was not familiar with the patients or ward processes and layout. The handover was disjointed and sometimes inaccurate. A healthcare support worker who was a regular member of the team had accompanied the nurse in charge to the handover and had to correct the report.
- Nurse managers for all wards were responsible for two wards each. This meant clinical nurse leads had to act up in their absence putting additional pressure on less experienced staff.
- Managers told us it was not easy to fully staff their wards. They had to try and locate staff from other wards before they could request bank or agency staff. Staff told us carrying out restraint procedures and high levels of de-escalation took precedence over routine ward work. Another staff member told us they often felt they were running on borderline safe staffing levels, and could not guarantee there would be a qualified nurse in all communal areas at all times. However, we saw sufficient numbers of staff in communal areas during our inspection. Patients and staff told us staff cancelled or delayed section 17 leave and escorted garden leave due to insufficient staff being available. The provider did not monitor this. However, two patients told us staff tried to do their best and they could access staff for advice or support at quieter times of the day.
- There was insufficient medical cover for overnight on call and emergencies. After midnight, there was only one on call doctor on duty for the whole of the St Andrews Northampton site.
- St Andrews target for mandatory training was 95%. Any wards below 90% were highlighted for attention in the nurse manager's weekly quality dashboard reports. There were 17 mandatory training courses. Fifteen courses had a compliance rate of over 75%. However, two courses were below the 75% compliance rate. Food hygiene certificate level two was 61% and management

of actual and potential aggression-five day programme at 51%. Of the remaining staff 47.5% were in date with Prevention and Management of Aggression and Violence training, leaving 1.5 % staff not trained in either approach.

- Staff were trained in different methods of physical restraint. This meant that staff used different restraint techniques and led to confusion between staff members when carrying out physical interventions. We were concerned that this might result in injury to patients or staff.

**Assessing and managing risk to patients and staff**

- There were 219 incidents of seclusion and one incident of long term segregation from 01 July 2016 to 31 December 2016. The ward that used seclusion the most was Sunley ward, they had used it 128 times. There had been one incident of long-term segregation on Stowe ward.
- For the period 01 August 2016 to 31 January 2017 there were 661 incidents of restraint. The highest number of restraints was on Sunley ward, they had 362 incidents of restraint for 12 different patients.
- The provider reported high levels of prone (face down) restraint. Staff used prone restraint a total of 298 times. Sunley had the highest incident of prone restraints at 236. The Mental Health Act 1983 code of practice states that staff should not place patients in the prone position unless there are cogent reasons for doing so. Following their last inspection the provider advised us they would be changing their practice to reduce the number of restraints and particularly prone restraint. At that time, the provider reported there had been 328 prone restraints, in a similar period, with Sunley ward reporting 106 prone restraints. Since the inspection in June 2016 incidents of prone restraint had decreased overall but had increased by 104% on Sunley Ward, based on data provided for the last six months. The provider advised that many patients on this ward had chosen to be restrained in the prone position due to past traumatic events. The ward also has a high turnover of patients, admits patients with high levels of physical aggression and self-harm, which in turn leads to a high use of restraint.
- Staff completed a risk assessment of every patient on admission. We reviewed 24 risk assessments and found that staff had updated all of them at regular intervals and after every incident.
- Staff used the following risk assessment tools, Short-Term Assessment of Risk and Treatability (START) and Historical Clinical Risk Management-20 (HCR-20). The initial risk assessment and management plans were developed with patients using a graded risk scale linked to lower observation levels and more access on the ward and outside areas.
- Wards had blanket restrictions in place. Some patients told us they had to go to their bedrooms at the same time each night. They explained this was because at night there were insufficient staff to carry out the required observations in more than one area at a time. The bedroom corridors were separate to the lounge and communal areas. Staff confirmed this was a usual practice, and for the reasons stated by patients. However, the provider advised that this is to protect patients from harm and to promote their wellbeing.
- We found further restrictions across all wards. For example, access to bedrooms in the daytime, kitchen areas, laundry and hot drinks. However, these were only used when justified and reviewed regularly on an individual basis.
- There were good policies and procedures for use of observation, including those used to minimise risk from ligature points. There was patient personal search policy, and a bedroom search policy that patients and staff we spoke with were aware of.
- We observed staff using verbal de-escalation to manage agitated patients. Staff were compassionate and skilled in their interactions. All staff we spoke with told us they used physical restraint as a last resort.
- Staff were unclear about the definitions and terminology being used to describe seclusion, long-term seclusion, segregation, extra care, restraint, and de-escalation. 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.
- Nurse managers and clinical team leads told us the new guidelines and policy relating to use and processes of seclusion and restraint had only recently become available to them and had not been fully cascaded to all ward staff.
- Staff did not complete seclusion records in a timely manner.

Good

# Forensic inpatient/secure wards

- We could not be sure that rapid tranquilisation was being used in accordance with national institute of health and care excellence guidance, because records were incomplete. In addition case records did not indicate that staff had completed all the required health checks after administrating rapid tranquilisation.
- Staff ensured paper copies of positive behaviour support plans were available on all wards, for ease of reference, and uploaded positive behaviour support plans to the electronic patient records. This meant that staff had ease of access to patient risks, triggers, and actions for safe care and treatment.
- There were effective processes for the storage, recording and administering of medication. Clinic rooms were clean and tidy. We reviewed 31 patients' prescription cards. Staff administered medication correctly and in accordance with guidelines and the provider's policy. The provider had its own pharmacy on site. Staff were able to order required medications with minimal delay for treatment of patients.
- Pharmacists completed clinical checks of medication records monthly and recorded in patients' case records. This included checks of consent to treatment and high dose anti-psychotics. The pharmacist completed controlled drug audits every three months.
- Staff were trained in safeguarding and knew how to make a safeguarding alert. Staff we spoke with showed good understanding of their responsibilities to report safeguarding concerns. Staff made safeguarding referrals via the provider's incident reporting system. Staff held safeguarding meetings to discuss management plans. We saw evidence of these meetings and associated action plans in patient records.
- The provider had arrangements for children to visit. Wards had dedicated rooms, away from the clinical areas where children could visit safely.
- Staff addressed outlier issues such as falls or pressure ulcers. We heard of staff referring one patient to the physiotherapists for an air mattress due to the high risk of her developing bed ulcers.

**Track record on safety**

- The provider supplied data showing that in the 12 months preceding this inspection there had been 38 serious incidents across five wards, they had not produced any similar data for Spencer South ward. The highest number of serious incidents was on Stowe ward with 14 incidents, the lowest being on Elgar ward with two incidents.
- The highest category of serious incidents (SI's) included self-harm, environmental incident, and medication incidents all of which occurred on Stowe ward.
- Staff told us about changes and improvements that had been made to practice as part of the learning from incident investigations including the empowerment of patients to take ownership of their own risk management plans.

**Reporting incidents and learning from when things go wrong**

- Staff knew what incidents to report and how to do this. Staff were able to demonstrate the type of incidents they should report and received feedback from investigations, both inside and outside the service, via team meetings and emails. The provider issued 'red alerts' to staff with information about adverse events and lessons learned.
- We saw evidence showing that staff reported all incidents that should be reported. Staff were able to describe what to report and how to report on the electronic system. We saw that incidents had been reported appropriately. However, the quality of the reports varied, with some reports not including sufficient detail and incidents not always being followed up.
- Staff were aware of their responsibilities under Duty of candour. This meant that staff were aware of their responsibilities to be open and honest when things had gone wrong for patients.
- The provider had systems in place to provide de-briefs for staff following incidents. However, some staff we spoke with told us they didn't always receive de-briefs after serious incidents. This affected staff morale and also prevented lessons being learnt. However, staff reported that senior managers were supportive to the teams when incidents occurred.

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

Good

# Forensic inpatient/secure wards

Good

### Assessment of needs and planning of care

- Staff completed comprehensive assessments for all patients, which they completed in a timely manner. We reviewed 24 patient care plans and they were up to date, personalised, holistic and recovery orientated.
- Staff completed positive behavioural support plans for patients. Staff updated care plans following discussion with patients in their multidisciplinary review meetings. Patients identified their own triggers to behavioural disturbance and relapse and identified ways that staff could support them during periods of agitation. Staff recorded patient views clearly in the care plans.
- Staff completed and recorded physical health examinations and assessments on admission. We found evidence that staff monitored physical observations and physical health problems. Staff discussed physical health needs at multidisciplinary team meetings and physical health was considered in care plans.
- The provider used an electronic recording system for patient care. Information needed to deliver care was stored securely and available to staff when they needed it in an accessible form. Information was co-ordinated when patients moved between teams and between the electronic and paper based systems. This ensured that information was readily available.

### Best practice in treatment and care

- Medical staff prescribed medication in accordance with national institute for health and care excellence guidelines. We found minimum levels of polypharmacy across all wards. Polypharmacy is a term used to describe the prescribing of four or more medications to one patient. Patients were less likely to experience side effects from their prescribed medication when staff prescribed fewer medications.
- Medical staff considered best practice in prescribing for patients. We saw evidence of patients being involved in decisions to reduce their levels of prescribed medication during their treatment. This indicated staff monitored patients' response to treatment and medical staff considered best practice when prescribing for patients.
- Psychologists delivered a variety of therapies for patients, which included cognitive behavioural therapy, dialectical behavioural therapy and schema-focused cognitive therapy. Occupational therapists encouraged patients in a range of activities of daily living, skills training, and diversion strategies. Both psychologists and occupational therapists offered patients individual and group work. Patients reported finding this input useful.
- The provider had a GP on site and a team of physical health nurses. We saw evidence on patients' notes of referrals to specialists when required. Staff escorted patients who required emergency treatment to the accident and emergency department at the local acute hospital. A dietician was available when needed.
- Staff met the nutrition and hydration needs of patients across all wards.
- Staff completed recognised rating scales, such as health of the nation outcome scales, and discussed outcomes in multidisciplinary meetings.
- The provider supplied details of clinical audits and dates for completion. Staff were allocated specific audits according to their roles. However, nurse managers told us that, at ward level, they allocated these tasks to team members when they were due. This meant that specific staff did not have overall responsibility for completing audits on a regular basis.

### Skilled staff to deliver care

- Wards had a range of staff to provide care and treatment including doctors, nurses, psychologists, occupational therapists, technical instructors, pharmacists, and social workers.
- The staff we spoke with were qualified to carry out their roles. However, managers told us many staff were new to the teams and therefore not as experienced as they would have liked. Experienced staff told us this put additional pressures on them until the new staff had gained the experience they needed.
- The provider offered substantive and bank staff corporate induction on joining the service. Dependent on job role, corporate induction was between one and five days, and included the mandatory training required for staff to be able to work safely and effectively. This included safety & security; safeguarding; health, safety & welfare; management of actual or potential violence (MAPA), foundation; basic life support; and intermediate life support. The provider consolidated the corporate

induction by further e-learning covering areas like information governance; equality, diversity and human rights, and Infection control. Staff were required to complete this e learning within one month of joining the service.

- On average 94% of staff had received supervision. This met the providers target rate of 85%. However, staff told us they often found it difficult to access supervision because they were required to ensure ward safety above training and supervision. Furthermore, they told us with limited staff numbers the need for ward safety took priority.
- The average compliance rate with non-medical staff having received appraisal in the last 12 months was 88%. The providers target was 95%.
- One hundred percent of doctors had revalidated during the period from 2011 to 2016.
- Managers addressed poor staff performance promptly and effectively. There had been three non-medical staff suspended or placed under supervised practice across the women's forensic service between 29 March 2016 and 23 January 2017. Following investigation, two of these staff had been given final written warnings, and one had been dismissed.

**Multi-disciplinary and inter-agency team work**

- We saw evidence, in the form of team meeting minutes, of effective and regular multidisciplinary meetings. Staff we spoke with told us these meetings were useful and kept them informed of things that were going on in the ward environment.
- We observed two shift handovers. The nurse in charge of the ward typed up notes relating to the care given to each patient on the ward and highlighted any concerns or incidents. These notes were shared with the team at handover and then placed in the ward information folder for staff to refer to during the next shift.
- Patients' case records showed effective working relationships including good handovers with other teams within the organisation. When required discussions had taken place with care co-ordinators and community mental health teams. However, staff told us shared care work and liaison with outside organisations, apart from at the time of admission and discharge, were not routine.

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

- Data for the period June 2016 to January 2017 showed 91% of staff had completed Mental Health Act training. The provider told us they organised e-learning refresher courses, as needed. We did not see compliance statistics for the refresher course training.
- Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles, and how these related to their area of work.
- Staff attached consent to treatment (T2) and capacity to consent (T3) documents to patient medication cards for staff reference. Overall medical staff completed these documents correctly.
- A competent staff member, as authorised by the hospital managers, examined Mental Health Act papers on admission. There were regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from these audits. The Mental Health Act administrators had a thorough scrutiny process using comprehensive checklists designed to highlight any errors or omissions. Despite this, we found one patient who had been detained illegally. The provider was taking appropriate action to address this.
- Staff generally completed Mental Health Act paperwork correctly. Staff stored original Mental Health Act paperwork securely in the Mental Health Act office and scanned documents into the electronic patient records for staff reference. However, we found staff had not scanned some paperwork. This meant that staff on wards might not have easy access to these documents, when needed.
- The service had clear records of leave granted to patients. Patients, staff, and carers where applicable, are aware of the parameters of leave granted, including risk and contingency/crisis measures.
- Staff told us they explained patients' legal status and rights under Section 132 of the Mental Health Act on admission, on renewal of detention and every six months as standard practice. We saw evidence of this in patient records. However, the electronic Section 132 form did not include the role of the Care Quality Commission in complaints about the Mental Health Act.
- The Mental Health Act administrators' co-ordinated hearings and tribunals for patients and automatic hearings on renewal of detention.
- Staff had access to the Mental Health Act Administrators for administrative support and legal advice. Staff told us this was both efficient and effective. Patients had access

to independent mental health advocates. Wards had posters detailing contact details and these were on display in the telephone rooms on wards. Patients could access independent mental health advocates directly by telephone. Staff made referrals on behalf of patients for independent mental health advocacy support on admission and as needed. We observed independent mental health advocates visiting patients on the wards.

**Good practice in applying the Mental Capacity Act**

- The provider advised us that Mental Capacity Act 2005 training was mandatory though it was not included in the mandatory training schedule. Only 61% of clinical staff were compliant with this training. However, staff we spoke with had adequate understanding of the MCA, in particular the five statutory principles and how they related to their area of work. Staff knew where to get advice regarding MCA, including Deprivation of Liberty Safeguards, within the organisation.
- A policy on Mental Capacity Act, including Deprivation of Liberty Safeguards, was available to staff. The provider monitored compliance with the Mental Capacity Act through regular audits.
- For patients who might have impaired capacity, staff assessed and recorded capacity to consent appropriately. We saw evidence on Spencer South ward where this had been done on a decision-specific basis, and the patient had been given every possible assistance to make a specific decision for them self before they were assumed to lack the mental capacity.
- When the doctor had established a patient did lack capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture, and history.
- Staff we spoke with were unsure about the Mental Capacity Act definition of restraint, there was also confusion around the definitions of seclusion, long-term segregation, and extra care.

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

(for example, to feedback?)

Good

Following our inspection in June 2016, we rated the 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 forensic inpatient/secure wards well-led?

Good

**Vision and values**

- The provider had a vision of "transforming lives by building world-class mental healthcare services". The provider values were compassion, accountability, respect and excellence.
- Staff we spoke with had good knowledge of the organisations vision and values. They were displayed in the public areas of the hospital. However, staff felt that they were not always able to uphold the vision and values, and some staff questioned whether their most senior managers were upholding them.
- We saw evidence that team objectives attempted to reflect the organisation's values and objectives.

- Staff knew the names of some of the most senior managers in the organisation, but felt there had been a lot of changes in the higher management structure and were no longer sure what titles or roles each senior manager performed because of those changes.

**Good governance**

- Managers ensured they monitored their team's compliance with mandatory training. At the time of the inspection two training subjects were below 75% compliance rate.
- Managers provided clinical supervision for staff. The average rate across the women's forensic service is 94%.
- The providers target for annual appraisal was 95% and the average across the women's forensic service was 87%.
- Managers did not ensure that all shifts were covered by a sufficient number of staff of the right grades and experience due to high vacancy rates. Whilst managers moved staff between wards to cover shifts or used bank or agency staff they did not reach the required numbers of staff. Staffing levels at night were particularly low. Staff were not always able to take breaks.
- Whilst managers directed staff to maximise shift time on direct care activities, this was often at the expense of staff supervision and training needs. Staff participated in clinical audits that were applicable to their role and experience.
- Managers ensured that incidents were reported using the electronic reporting system. We saw evidence in team minutes of managers informing staff of lesson learnt from incidents and complaint investigations.
- The provider used key performance indicators and other indicators to gauge the performance of the team. These included indicators for training, safety, quality and efficiency. The measures were in an accessible format and used by the nurse managers and clinical nurse leads who developed action plans where there were issues to be addressed.
- Nurse managers had sufficient administration to carry out their duties.
- Senior clinical teams did not always feel their clinical decisions were respected or supported by the most senior managers and that multidisciplinary team decisions were often over ruled.
- Staff had the ability to submit items to the St Andrews risk register.

**Leadership, morale and staff engagement**

- The provider submitted key results from their 2016 staff survey. They had a 64% return rate. 86% of staff who responded to the survey said they were willing to give extra effort to help the organisation its goals. 86% of staff who responded said they believed St. Andrews looked after the patients with care and compassion, and 84% of staff who responded said that within their team they constantly looked for ways to do their job better.
- Areas for improvement included, clearer communication of the organisations vision and goals; development work around empowering nurse managers and staff; more focus on reward and ensuring staff feel valued; and addressing perceptions of low staffing, bureaucracy and existing processes.
- Staff sickness levels were relatively low at 3% for the period January 2016 to February 2017.
- Staff told us that if time allowed there were opportunities available for developing leadership skills within St Andrews Healthcare. Staff explained development of these skills was underpinned by the annual appraisal system and included opportunities for experiential learning on the job, objective and goal setting, career planning and formal study either in house or externally.
- Staff knew how to use the whistle-blowing process. Staff told us they were more likely to use whistleblowing rather than the formal grievance or complaints procedures as this would retain their anonymity.
- Some staff we spoke with during the inspection told us they perceived there was a bullying culture in higher and senior management levels, particularly if a person made it clear they did not support an organisational decision.
- Staff at ward level reported low morale. However, they reported feeling supported by colleagues within their teams. Staff we spoke with expressed concerns about staffing levels and the perceived inappropriate placement of a few recent patient admissions.
- Multidisciplinary teams worked well together across all wards, for the benefit of patients.
- Senior staff told us their teams were aware of their responsibilities to be open and honest with patients when things went wrong.
- There were governance processes in place to monitor quality, performance and take appropriate action following serious incidents. 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.

- We saw evidence of this in minutes of MDT and team meetings on wards. However, six staff told us they firmly believed their views were not taken on board by the decision makers.

**Commitment to quality improvement and innovation**

- The provider told us about their Collaborative Ward Reviews. These reviews identified areas of good practice, and facilitated a culture of inquiry into clinical practice and delivery of care on the wards and within the clinical team. This in turn facilitated a desire for constant improvement through reflective learning.
- The provider had completed a trial for positive behaviour support plans on the forensic and rehabilitation wards. This was successful and will be rolled out across the organisation.
- The service had established a patient- carer reference group to work with staff to review, develop and improve patient experience.
- The provider had engaged in the Quality Network for Forensic Mental Health Services, this had been booked for 21st March 2017 and they were awaiting the outcome.

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

Good

| | |
|---|---|
| Safe | |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Are long stay/rehabilitation mental health wards for working-age adults 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 :

**Safe staffing**

- The provider set the core staffing levels for the service. The established level of registered nurse was 19.9 whole time equivalent (WTE). At the time of the inspection, there were 9.9 vacancies. The established level of unqualified staff was 30.3 WTE. The service has 8.9 unqualified vacancies.
- Due to staff shortages, managers relied heavily on bank and agency staff to cover the vacancies. From 01 November to 31 January 2017 bank or agency staff, due to sickness, absence or vacancies covered 969 shifts. However, 287 shifts had not been covered, which resulted in wards working below the numbers required to meet the needs of patients.
- The staff that managers used were not always known to the service or familiar to the wards or patients.

**Assessing and managing risk to patients and staff**

- Some patients were not able to access their bedrooms in the daytime and did not have access to the kitchen to make their own hot drinks. This was based on individual risk assessments.
- Staff had stopped patients having caffeinated drinks at Springhill House. Staff imposed this restriction following an incident of one patient giving another a caffeinated drink when they should not have done.
- Staff placed a restriction on the movement of patients at Spring Hill House. When patients were not in DBT or other therapy staff requested they remained in area B of Spring Hill House. However, the unit is specifically for patients requiring DBT and patients are expected to participate in therapy. Some of the patients risk ratings allowed them allowed them access to the less restrictive area C of the unit or the garden but staff prevented this. Staff told us this restriction was in place as there was often insufficient staff to safely observe more than one area.
- We found that area B was not large enough to accommodate 20 patients that were currently at Spring Hill House. This area was used daily by all patients and there were not enough chairs. This meant that patients and staff had to sit on the floor. The dining room only accommodated 16 patients to eat sitting at a table.
- Patients we spoke with reported that staff used 'punitive' measures to encourage them to engage in therapy. Two patients reported that access to their own mobile phones was dependent upon them engaging in the dialectical behaviour therapy programme. Other patients told us they were too afraid to speak up or challenge staff, because they believed this would lead to their "privileges" being withdrawn.
- Some patients told us they had to go to their bedrooms at the same time each night. They explained this was because at night there were insufficient staff to carry out the required observations in more than one area at a time. The bedroom corridors were separate to the lounge and communal areas. Staff confirmed this

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

Good

was usual practice and for the reasons stated by patients. However the provider advised this was to protect patients from harm and to promote their wellbeing.

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

(for example, treatment is effective)

Good

### Assessment of needs and planning of care

- Staff completed comprehensive assessments for all patients, which they completed in a timely manner. We reviewed 12 care records and they were all up to date, personalise, holistic, recovery orientated and identified individual goals. Doctors had carried out comprehensive assessment at the time of admission. Staff had updated the records after multidisciplinary team meetings.
- Care records included positive behaviour support plans and my shared pathway.
- Care records showed physical examinations had taken place at the time of admission and periodically thereafter. We saw evidence of patients having received podiatry and dental care.
- All information needed to deliver care was stored securely and available to staff when they needed. Information was in an accessible format, regular bank and agency staff had the same access to electronic care records as permanent staff.

### Best practice in treatment and care

- Doctors prescribed medication in line with national institute of health and care excellence guidance. If patients were prescribed high doses of medication, doctors completed additional care plans to ensure staff were aware of risks and carried out additional monitoring of the patients physical health.
- The 12 care records we reviewed highlighted that staff were following national institute for health and care excellence guidance around treating people with borderline personality disorder. Staff recorded patient's progress through the dialectical behaviour therapy program.
- The multidisciplinary team offered a comprehensive dialectical behaviour therapy program including one to one support as part of the program. Occupational therapists also assessed patient's skills and risks for using the kitchen area and the laundry and offered one to one and group work to promote patients' rehabilitation and independence.
- Four patients we spoke with told us how effective this structured way of working was. Although two patients told us that if they did not want or were unable to participate in dialectical behaviour therapy, there was not many alternative psychological therapies available. Staff on the ward supported this view.
- St. Andrews Hospital had its own physical healthcare team who saw patients on the wards. Patients told us the physical healthcare team were very good and could deal with most physical healthcare matters. We saw further evidence of this in patients care records. However, the physical healthcare team were only available from Monday to Friday.
- Staff monitored and recorded patient food and fluid intake where appropriate. We saw evidence in two care records that staff had recorded food and fluid intake for patients, particularly where staff had identified previous issues with patients restricting their food.
- Staff used health of the nation outcome scores (HONOS) to assess and record severity and outcomes of patient's mental health and progress or deterioration.
- Frontline staff participated in clinical audits that were appropriate to their role and grade, for example hand hygiene and security audits. However, the providers audit team completed most audits.

### Skilled staff to deliver care

- The multidisciplinary team consisted of doctors, nurses, clinical psychologists, occupational therapists, and social workers.
- Most members of the multidisciplinary team had undertaken specialist training to facilitate the daily structured dialectical behaviour program. This was the primary form of psychological therapy provided on Springhill House. We saw and heard how staff carried dialectical behaviour principles through to patients risk planning and risk management, recovery goals, and discharge.
- Staff received a structured induction lasting from two days to five days depending on their grade and roles within the team. Staff confirmed that while induction

provided them with initial training and opportunities to learn about the organisation, it could take several months to feel fully confident working on the wards. Due to the amount of new staff and agency staff on the wards, a high proportion of the ward teams were inexperienced.
- Managers ensured that staff had received supervision, annual appraisal and that they had access to regular team meetings. Across the service, the average compliance with supervision was 97%.
- Managers ensured that 92% of non-medical staff had completed their appraisals in the last 12 months.
- One hundred percent of doctors had revalidated themselves in the previous 12 months for the period 2011- 2016.
- Managers had addressed poor staff performance promptly and effectively. Three non-medical staff had been suspended or were under supervised practice across women's services.

**Multi-disciplinary and inter-agency team work**

- The multidisciplinary team meetings tool place weekly to review patients' progress and to address any issues with patients care and treatment.
- Staff met at the beginning and end of shifts to handover information regarding patient care. This included information on individual patient's risks and how patients had interacted during the shift. The nurse in charge of the shift formulated notes about each patient in preparation for this meeting, as well as updating the patients care records. After the meeting, staff filed these notes in the ward communication book so that other staff coming on duty later in the shift could keep up to date with patient activity. In addition to the ward notes, any staff coming on duty during the shift received appropriate verbal handover.
- Staff communicated with other teams in the organisation when necessary. For example, staff recorded in case records communication between wards when a patient was due to be transferred.
- Staff liaised with outside agencies when required. We saw an example where staff had been in contact with a local authority regarding access visits for a patient's child and correspondence with a housing authority trying to secure appropriate accommodation for a patient on discharge.

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

- A competent member of staff checked Mental Health Act paperwork on admission. Administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice was available from a central team.
- Staff knew who their Mental Health Act administrators were and how they could access them for support to ensure they followed the act correctly in relation to renewals, consent to treatment and appeals against detention.
- Staff completed detention paperwork in a timely manner. Staff filled in paperwork correctly and stored paperwork safely and appropriately.
- Patients could access leave in the grounds or in the community dependant on risk. However, five patients told us they had had section 17 leave cancelled due to the wards being busy and staff were diverted towards managing other patient's high observation, restraint, and seclusion procedures.
- The service kept clear records of leave granted to patients. Patients, staff and carers where applicable were aware of the parameters of leave granted, including risk and contingency and crisis measures.
- Staff assessed patient risk prior to leave and recorded how patients were feeling on return. Patients accessed work placements and education whilst on leave, where appropriate, to support their rehabilitation.
- Seventy six percent of staff had completed training in the Mental Health Act. Staff we spoke with had a good understanding of the Mental Health Act, the revised Code of Practice and the guiding principles.
- Staff ensured that they completed consent to treatment and capacity assessments. We saw that staff had attached copies of consent to treatment forms to medication charts where applicable.
- Staff had informed patients of their verbal and written section 132 rights about their legal status, on admission, and thereafter at six monthly intervals. It was unclear when a patient refused their rights, when staff would revisit this.
- The service displayed independent mental health advocacy information across all wards. This included the role of the independent mental health advocate and

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

Good

contact details. We saw how staff had made preparations for an advocate and second opinion doctor who were attending a review meeting with a patient and her family.

**Good practice in applying the Mental Capacity Act**

- Sixty eight percent of clinical staff were trained in Mental Capacity Act.
- Staff had good understanding of the Mental Capacity Act 2005, in particular the five statutory principles, and how they applied to their work roles. There was a policy on Mental Capacity Act including Deprivation of Liberty Safeguards, which staff were aware of and could refer to.
- Staff knew where to get additional advice regarding Mental capacity Act including Deprivation of Liberty Safeguards. The provider monitored adherence to the Mental Capacity Act through regular audits.
- Staff completed Deprivation of Liberty Safeguards applications when required. Staff had made no deprivation of liberty safeguard applications in the 6 months preceding this inspection.
- Staff completed capacity assessments and discussed the outcomes in the multidisciplinary meeting. One example we reviewed showed the rationale for the assessment, and that it was decision specific. We saw how staff had given the patient assistance to contribute to the decision making as far as possible, before staff assumed the patient lacked capacity to make the decision herself.
- The multidisciplinary team made decisions in the best interest of the patient while recognising the importance of the person's wishes, feelings, culture and history.
- However, staff were unsure about the Mental Capacity Act definition of restraint and the difference between restraint, de-escalation in the quiet room and seclusion.

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

Good

**Vision and values**

- The provider had a vision of "transforming lives by building world-class mental healthcare services". The provider values were compassion, accountability, respect and excellence.
- Staff described the values of the organisation and how they applied to their work with patients.
- Staff were aware of the senior managers in the organisation and reported that modern matrons visited the service. Staff were unable to recall the last time members of the board visited the service.

**Good governance**

- The training team recorded and monitored training compliance and provided operational managers with alerts when staff required training. Managers did not have immediate access to this information to check overall training compliance for their wards. Fifteen out of 17 mandatory training session compliance rates were above 75%.
- Managers ensured that staff received regular supervision and carried out annual appraisals with staff.
- Managers encouraged staff to maximise their time in patient care as opposed to administration, and were encouraged to remain visible and on the wards as much as possible.

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

Good

- Staff participated in clinical audit that was applicable to their grade and professional background.
- Managers had robust systems in place for reporting and investigating incidents and complaints. Managers fed back the outcomes and findings from these investigations to staff through team meetings.
- Managers ensured that staff complied with safeguarding, Mental Health Act and Mental Capacity Act procedures and policies.
- The provider used key performance indicators and other indicators to gauge the performance of the team. The measures were in an accessible format and used by the staff team who develop active plans where there are issues.
- Ward managers felt they had sufficient authority and admin support to undertake their roles effectively.
- Staff had the ability to submit items to the providers risk register. Two managers gave us examples of when they had done this including concerns about staffing and inappropriate referrals to their wards.

**Leadership, morale and staff engagement**

- The provider submitted results from their 2016 staff survey. They had a 64% return rate. 86% of staff who responded said they were willing to give extra effort to help the organisation its goals. 86% of staff said they believed St. Andrews looked after the patients with care and compassion, and 84% of staff said that within their team they constantly looked for ways to do their job better.
- Areas for improvement included clearer communication of the organisations vision and goals; development work around empowering nurse managers and staff; more focus on reward and ensuring staff feel valued and addressing perceptions of low staffing, bureaucracy and existing processes.
- Sickness and absence rates for Thornton ward and Springhill House for the period February 2016 – January 2017 were 2.7% and 5.4 % respectively.
- Staff knew how to use the whistle-blowing process. However, staff told us they were more likely to use whistleblowing rather than the formal grievance or complaints procedures as this would retain their anonymity.
- Some staff we spoke with during the inspection told us they perceived there was a bullying culture in higher and senior management levels, particularly if a person made it clear they did not support an organisational decision.
- Staff reported low morale, but did feel supported by colleagues within their teams. Staff we spoke with also expressed concerns about staffing levels, and the perceived inappropriate placement of some more recent patient admissions.
- Managers provided opportunities for developing leaderships skills. However, this was at times, difficult to attend due to staffing levels. Staff explained development of these skills was underpinned by the annual appraisal system.
- Multidisciplinary teams worked well together across all wards, for the benefit of patients.
- Senior staff told us their teams were aware of their responsibilities to be open and honest with patients when things went wrong.
- Staff attended regular team meetings and were able to give feedback on services. We saw evidence of this in minutes of multidisciplinary and team meetings on wards.

**Commitment to quality improvement and innovation**

- Having completed a trial on the forensic and rehabilitation wards they now planned to roll out positive behaviour support plans across the organisation.
- The service had redesigned their annual mandatory refresher training in conflict management to include assessment of competence.
- The service had established a patient- carer reference group to work with staff to review, develop and improve the patient experience.
- The provider had engaged in the Accreditation for Inpatient Mental Health Service (AIMS) schemes (Thornton Ward) and was awaiting the outcome.

Good

# Wards for people with learning disabilities or autism

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

## Are wards for people with learning disabilities or autism safe?

Requires improvement

### Safe and clean environment

- Both wards had a clear layout for staff to be able to observe most of the ward and garden. There were mirrors in place for staff to observe corridors on Spencer North ward. Patients were individually risk assessed and staff carried out regular observations.
- 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. A ligature audit highlights and addresses any potential risks on a ward. Patients may be able to harm themselves with a ligature point. Staff mitigated these through environmental risk management for each patient. The ligature audit was up to date.
- Clinic rooms were equipped with a couch, scales and blood pressure monitors. Medications and resuscitation equipment were available in case of emergency. Records showed staff carried out daily checks to ensure they were in date and would work properly if needed.
- Emergency equipment and medication was shared between wards, which had to be accessed through locked doors. Regular health and safety checks were carried out to assess staff response time, which was within 4 minutes.
- The seclusion rooms, extra care suites and low stimulation rooms all met required standards of safety, comfort and cleanliness. The seclusion rooms had two-way observation, toilet facilities and a clock. Staff completed cleaning records for the seclusion rooms and undertook environmental risk assessments of the seclusion areas as required.
- All ward areas were clean. Cleaning schedules were seen, and we observed dedicated cleaners carrying out their duties.
- 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 carried out infection control audits every month. An external infection control nurse carried out yearly audits. The infection control policy was in date. We saw staff washing hands and posters were displayed for both patients and staff to identify good hand hygiene practices.
- Across all wards staff had access to alarms which they carried on their belt and if activated pinpointed their location. Staff called for further assistance across the site using a radio.

### Safe staffing

- Staffing numbers on both wards did not meet establishment levels and extra staff were needed to cover increased observation and enhanced care.
- Spencer North ward reported establishment figures of 7.5 whole time equivalent qualified nurses and 14 whole time equivalent health care assistants. The establishment level required there to be 10 qualified and 15.5 health care assistants in post for this ward. Sitwell ward reported establishment of six whole time equivalent nurses and 19 healthcare assistants. There were seven qualified nurse vacancies and four

healthcare assistant vacancies on this ward. Managers said there were four new staff starting in the next two weeks. There was a vacancy for a ward manager on Sitwell but the provider was actively recruiting. In the meantime, the modern matron was in charge of the ward.

- The ward managers could increase staffing numbers to meet increased observation and enhanced care needs of patients. The provider had their own bank staff and they used regular agency, whenever possible, if needed. However, where agency staff were used they did not have access to all of the systems, adding more responsibilities onto the permanent staff.
- From 1 November 2016 to 31 January 2017, bank staff filled 440 shifts on Sitwell ward and 575 on Spencer North. This was in line with agency use across the LD/ ASD pathway. Managers told us that agency use was decreasing.
- Three patients said they felt concerned for staff safety, they told us they knew staffing levels were low. When there was an incident they felt that staff and patients were at risk of harm.
- Staff were aware of whom to contact when seeking medical advice day or night. Staff said they could contact the on call doctor during the night or out of hours.
- Staff and managers said activities and leave are rarely cancelled due to short staffing. Of the records we reviewed we did not see any cancelled leave.
- Staff received mandatory training and more than 93% were compliant. The providers target for mandatory training is 95%. Some staff had also received specific training in positive behaviour support planning. There were also sessions on the ward as part of reflective practice to support staff in positive behaviour planning .
- In January 2016 the provider had introduced the management of actual and potential aggression (MAPA) training with 50% of staff on Sitwell, and 60% on Spencer North having received the training. However, we identified that some staff trained in the previous Prevention and Management of Aggression and Violence (PMAV) were out of date, whilst they were transferring from PMAV to MAPA. Due to short staffing levels, managers could not assure that there were enough staff trained in MAPA on duty for each ward, or that these staff had experience in dealing with restraint and incidents. MAPA places more emphasis on de-escalation and preventing aggression. Staff we spoke with were knowledgeable about the differences in each training and said that the person taking the lead in any restraint situation would direct the staff in how to respond.

**Assessing and managing risk to patients and staff**

- In the six months preceding this inspection, Sitwell ward had 104 incidents of use of seclusion and two patients were segregated long-term. On Spencer North there were 19 seclusions. This was high on Sitwell due to the patients being mainly admitted to this ward at the start of their treatment pathway, so were often more unwell that the patients on other wards.
- Data for the period 1 August 2016 to 31 January 2017 showed there had been 534 restraints in this service across both wards. Three hundred and one restraints had been on Sitwell and 233 had been on Spencer North ward. Of the 301 on Sitwell ward, 265 had been held for ten minutes or less, on Spencer North ward 148 of the 233 had been for ten minutes or less. St Andrew's Healthcare records all hands on contact with patients as restraint.
- Of the 301 incidents of restraint on Sitwell ward, 114 used the prone position. Staff used prone position on 36 occasions to administer medication and on 26 occasions to exit seclusion. One patient preferred to put herself into prone position.
- Of the 233 incidents of restraint on Spencer North, 54 used the prone position. Staff used prone position on 20 occasions to administer medication. Staff told us the majority were actually for less than a minute but the system did not capture this amount of time as the data provided could only record less than three minutes as the minimum time.
- Staff used distraction techniques and talked calmly to patients to help manage behaviours. Staff we spoke with understood which techniques usually worked with individual patients. Staff said that restraint was always a last resort. We looked at patient restraint records and found that staff had recorded restraint holds when necessary. We reviewed the number of restraints broken down monthly. There was a significant reduction of restraints across both wards. From 60 in August 2016 to eight in May 2017 on Sitwell and 61 on Spencer North in August 2016 to 24 in May 2017.
- We reviewed 11 care and treatment records across both wards. It was difficult to locate detailed risk assessments that included the use of restraint. We saw in all 11

patients Personal Behaviour Support plan's, restraint and aggression management was discussed. One record had an individual use of restraint plan for a patient who had a long term injury, two records had an updated Prevention of Violence and Aggression plan exploring the use of holds. Staff completed the Short Dynamic Risk Scale (SDRS), which allowed staff to assess risks for patients with learning disabilities. However, staff had not completed the section that describes the plan on how to reduce problem behaviours.

- Restrictions were only used when justified. Managers said staff understood and worked toward the least restrictive practice available, managers encouraged a pro-active approach and culture.
- Staff carried out regular ward observations for each patient. Where patients were being observed on a one to one or two to one, staff completed observation records detailing the patient's behaviours.
- Staff followed the national institute for health and care excellence when administering rapid tranquilisation. The provider's tranquilisation policy was updated during June 2016 and included guidance from the Royal College of Psychiatry.
- We reviewed patient seclusion records. Staff had been provided with a new seclusion pack outlining best practice. However, on Sitwell ward staff did not complete the new record fully and the check lists were incomplete. We could not identify the official start time of one seclusion episode and the end time was not filled in. We reviewed a mixture of documents and entries for seclusions in patient records, and could not locate some medical reviews for patients during seclusion, one medical review was input into the system two hours after a patient's seclusion had ended. Two patients on Spencer North did not have a seclusion care plan in place, one patient had been secluded on 21/03/2017. When we reviewed records on 17/05/2017 there was no seclusion care plan in place.
  One patient had a seclusion care plan that was dated 4/05/2017, staff had not updated this care plan for an episode of seclusion on 13/05/2017.
- Ninety five per cent of staff had completed safeguarding training across the women's pathway. Staff knew what should be reported under the safeguarding procedures. We saw records where staff had dealt with a potential safeguarding issue.
- A pharmacist attended the wards once a week to carry out audits and ensure staff followed national institute for health and care excellence guidelines in managing medicines. Medicines were secured appropriately. Staff checked room and fridge temperatures to ensure medicines were kept as per manufacturing guidelines. On Spencer North ward staff recorded on six occasions between January and May that the fridge temperature was above the recommended range. However, we saw evidence that this issue had been resolved and all temperatures were being recorded appropriately at the time of the inspection. Staff reported and logged any medication errors and pharmacy contacts were available.
- During our inspection, staff provided information about which patients on the ward may be distressed to see us. Staff and managers were clear on how we should respond to patients in this situation. This demonstrated safe management for patients, visitors and staff and effective management of de-escalation.
- The hospital allowed families and children to visit patients. This is booked in advance so managers can ensure staff are available to attend.

**Track record on safety**

- In the last 12 months there were 11 serious incidents reported on Spencer North ward. Three were allegations of abuse and three for medication errors. The others were safeguarding. On Sitwell, there were two incidents. Managers had investigated these incidents and taken action to reduce the risk of reoccurrence.
- We looked at incidents related to restraint. There was an incident reported in November 2016 when a patient reported a member of staff physically abused them during restraint. Managers investigated the incident and took appropriate action. A management plan was put in place to support the patient.

**Reporting incidents and learning from when things go wrong**

- Staff recognised and reported incidents using an electronic reporting system. We saw staff reported a range of incidents.
- The provider had updated the incident reporting system to enable clearer analysis on restrictive interventions. This included detailing the reason for the use of prone

restraint. Staff reported episodes of restraint as an incident on the electronic system. The ward manager and senior managers received a trigger alerting them to the incident report and they would then review it.

- The provider had a policy of recording all hands on contact with patients as restraint. This could include guiding someone by the arm to the low stimulation room.
- Staff discussed restraint incidents and seclusion at multidisciplinary meetings (ward reviews). The ward managers received a monthly dashboard report, containing information about the incidents of restraints and seclusion. One manager showed us a breakdown of when incidents occurred during the week, identifying any individual triggers. This manager explained that they were then supported to put in extra staffing during those shifts.
- The training leads for managing aggression and for positive behaviour support planning attended the wards when requested to help staff learn from incidents and review the use of restraint. This included how to do things differently if appropriate.
- Staff were open and transparent to patients when something went wrong, we saw an example of a letter given to a patient summarising what was done when something went wrong. Patients said they were told about the outcome of incidents.
- Managers and psychology offered staff support after any serious incidents. However, two members of staff said they did not get informed of outcomes following incidents. Two members of staff said because of short staffing reporting took them longer.

## Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

### Assessment of needs and planning of care

- We reviewed 11 care and treatment records, staff completed a comprehensive assessment of patient needs, during a multidisciplinary team meeting within 72 hours of each patient's admission.
- Staff completed an initial physical healthcare examination and monthly thereafter. This included referrals to the dentist, dietician and hospital if needed. However, we could not always locate an outcome from patient appointments, within patient notes. We saw all care plans had an up-to-date health action plan for patients to follow which included physical care.
- All positive behaviour support plans were current, staff gave patients copies of these if they wanted. The positive behaviour support plan included distraction techniques, soothing ideas and ways patients and staff could manage behavioural distress. The multidisciplinary team held a monthly group to review the progress, quality and implementation of these.
- The hospital used an electronic record system for patient care records. Staff could access a patient's record if they had moved ward. However, we found it difficult to locate continuous, clear records that allowed us to follow the patient's treatment pathway.
- Staff involved individual patients in reviewing their good behaviours. Staff would identify patterns and score these behaviours, helping patients to build awareness of when good behaviours occur.

### Best practice in treatment and care

- Staff followed national institute for health and care excellence when prescribing and monitoring patients' medications.
- A range of psychological therapies recommended by the national institute for health and care excellence was available for patients. A psychology team with learning disability expertise worked with education and social needs on site. Interventions were adapted based on comprehensive assessments to meet the needs of the patient group.
- A GP visited the wards, and nursing staff ran weekly clinic sessions for patient's physical healthcare needs. A physical healthcare nurse was also available. Patients had hospital and dental appointments when needed.
- Staff used recognised rating scales to assess and record outcomes. For example, the use of health of the nation outcome scales for patients with learning disabilities.

### Skilled staff to deliver care

- There was a range of mental health disciplines, qualified nursing staff, trained support workers, psychiatrists, a speech and language therapist, occupational therapists and a social worker on site. This meant that patients had access to a variety of skilled staff to provide care and treatment.

- New staff received an induction; managers reviewed their performance during their induction period and in supervision. New health care workers completed the Care Certificate during their probationary period. Learning was conducted through the university as part of probation. Managers said staff working on these wards could have Learning Disabilities specific training. Managers said they hoped to support patients to engage with staff training opportunities.
- Staff had some access to appropriate training and development. Records showed staff had completed training that was relevant to their role. Staff said they had opportunities to develop the skills they needed through training. For example, autism awareness and developing positive behaviour support plans. However, six staff said they were not always provided with the means to engage with additional training.
- Managers told us they were running an 'Aspire' programme which is a 'grow your own' nursing programme where they support individuals to become qualified nurses.
- One hundred per cent of staff had an up to date appraisal on Spencer North, and on Sitwell ward, 83% of staff appraisals were up do date.

**Multi-disciplinary and inter-agency team work**

- There were multidisciplinary meetings weekly. Managers discussed patient incidents, reviewed medication and staffing. Patients were supported to attend these meetings.
- Ward staff completed a handover at the start of each shift, managers and staff discussed the observation level, patient behaviour, patient mental state, any risks presented, positive behaviours, medication compliance and physical health for each patient. However, handover records were not always kept in a clear location for staff to review. We looked at the folder for Sitwell ward and saw three handover logs for April 2017, November 2016 and September 2017. Staff said they did not always record what is said when a handover took place and they were compromised when shifts were short staffed. Records did not show regular effective handovers took place or included handovers for external teams.

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

- The hospital had a Mental Health Administrator who carried out audits of Mental Health Act papers to ensure detentions remained legal.
- Staff knew who they could seek advice from regarding the Mental Health Act. However, from records we reviewed staff were not always clear about how or when to continue to record and update patients capacity.
- We saw clear records of section 17 leave granted to patients. Where patients had not had leave, staff gave explanations, such as the patient being unsettled or too unwell. Staff recorded the time of section 17 leave, recording an explanation of outcomes. However, in six patient records, staff were not providing any more detail of the outcome of leave other than stating it was successful. We could not locate a clear contingency or crisis plan for staff to follow during a patients leave.
- The hospital provided mandatory Mental Health Act 1983 training. Training records showed 75% of staff completed this as part of their induction as an online learning.
- Staff we spoke with could describe the basic principles of the Mental Health Act and demonstrated to us they knew about the Code of Practice. Staff said they would ask managers for advice should they need to. Staff worked as a team and discussed reading patients' rights. We saw each ward had an up to date Code of Practice and staff had access to the hospitals Mental Health Act policy, along with the Mental Health Act administration team.
- Records showed staff kept a copy of patient consent to treatment and capacity requirements with medication charts. We observed good self-medication practices between staff and patients. Patients on Spencer North were encouraged to be involved with taking their own medication.
- Patients said they knew their rights. Records showed that patients had their rights explained to them regularly; staff noted on their case notes if a patient did not understand and redelivered or explained to them in a different format.
- The hospital Mental Health Act administrator carried out audits on patient's detention paperwork. However, we could not see any evidence of learning at ward level, from these audits. Staff were unsure as to how audits were carried out.
- Patients across the hospital could access an independent advocate, who is specially trained to support people to understand their rights under the

Good

# Wards for people with learning disabilities or autism

Mental Health Act and participate in decisions about their care and treatment, by pressing a speed dial number available on the patient phone. Patients we spoke with told us they had used this service and knew how to access it.

**Good practice in applying the Mental Capacity Act**

- Records showed 75% of staff had training in the Mental Capacity Act.
- There were no Deprivation of Liberty Safeguard applications made in the last six months.
- Staff we spoke with said they received training in the Mental Capacity Act, they said they considered all patients to have capacity and understood the principles.
- Staff supported patients to make their own decisions where possible.
- The multidisciplinary team discussed capacity assessments during ward rounds. Managers would circulate an updated feedback form to staff weekly. We saw patient note entries where staff discussed capacity with the patient. Care plans reflected patient views around medication, interventions and decisions.
- Staff knew where to get advice regarding Mental Capacity Act and Deprivation of Liberty Safeguards within the hospital.

## Are wards for people with learning disabilities or autism caring?

Good

**Kindness, dignity, respect and support**

- Across both wards, we observed different disciplines of staff to be caring, and engaging with patients. Staff were caring and respectful in their approach to patients and showed an understanding of individual need. They spoke about patients in a respectful manner.
- Most patients said regular staff treated them with respect. However, four patients said staff could be snappy when they are under pressure and some staff were rude.
- Both wards had some challenging patients, managers and staff worked extra shifts to support the wards, which showed resilience and commitment toward delivering patient care.

**The involvement of people in the care they receive**.

- Patients were involved in their care planning unless they had declined. Care plans evidenced that patient preferences had been included and were individualised. Care plans were available in easy read format.
- Three patients said since going to St Andrews, they felt they had developed coping skills, become better at managing their aggression and had improved with the help from staff.
- Patients were positive about the psychology team and the group work on offer. One patient explained some of the mindfulness skills they had put into practice and another said they were pleased they had learnt skills.
- Carers were involved in care review meetings where possible. Staff would telephone conference family members when they were unable to attend meetings. Two family members said staff explained things clearly and were happy with the treatment their loved one was receiving.
- Advocacy services were available to patients if requested. The provider displayed information on advocacy services in communal areas. Patients could contact advocacy services directly or staff on the wards would refer patients to advocacy.
- Three patients said they felt encouraged to bring any ideas about the service to community meetings. Staff held community meetings on each ward weekly. Patients discussed bullying, meals, activities, staffing and incidents. One patient said they felt most issues were addressed, and they got an explanation in return from management.

## Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

**Access and discharge**

- Average bed occupancy over the last six months was 83% on Sitwell and 75% on Spencer North ward, with the average length of stay being 911 days and 760.
- Managers on Sitwell ward said there was a current hold on admissions due to there being a couple of

challenging patients, staffing levels were lower than required so accounted for any additional support needed for patients safety. Managers said senior staff within the hospital supported these decisions.

- The hospital accepted patients from all parts of the country. If possible, patients were discharged to a suitable placement closer to home. Staff and managers arranged meetings with patients' local commissioners, social workers and community mental health teams. We saw minutes of a teleconference meeting that took place for a patient who lived over 100 miles away, the meeting was to discuss this patient's progress and likelihood to go to a step down flat. Two patients said they talked to their community mental health worker on the phone whilst in hospital.
- Staff developed discharge plans for patients, which included housing options, education and employment. We saw one patient had first lines of agreement with commissioners, to give the patient a bespoke package of treatment within the community. Staff recorded in patient care plans what steps the patient needed to take before appropriate final discharge plans could be made. Patients told us about discussions they had had about discharge planning, one patient said they were getting some work experience at St Andrews and would look to go into employment in their area once discharged.
- Patients who went on section 17 leave, had access to their own bed upon return.
- Managers said there is a bed available in the hospitals Psychiatric Intensive Care Unit (PICU) if a patient became unwell during their admission on the ward.
- The hospital reported there was one delayed discharge in the last 12 months on Spencer North, this was because there was not a suitable community place available.

**The facilities promote recovery, comfort, dignity and confidentiality**

- There was a full range of rooms available within the hospital. Patients from both wards attended the gym, art room and separate kitchen if they wished to engage in activities and learn to cook some meals.
- Spencer North ward had a separate lounge where patients could watch a film or TV. There was a dedicated visitors' room off the wards.
- Patients had access to a pay phone. Staff would give patients a portable phone if they wished to speak in their room. This was risk assessed.
- Patients had access to outside space both on the ward and off the ward if assessed.
- Patients could choose their meals from a menu. Some patients said the food was not always very nice and was cold or dry by the time the kitchens had delivered it to their ward.
- There were hot drinks and snacks available to patients throughout the day.
- Patients personalised their bedrooms, patients said they felt their rooms were big enough. We saw patients had personal possessions in their room. For example, photographs, large televisions and films. Patients could lock some personal possessions in a cupboard and staff kept some items locked in a restricted area.

**Meeting the needs of all people who use the service**

- There was disabled access on Sitwell ward. On Spencer North ward the assisted toilet facilities were upstairs, staff would assist patients upstairs using a lift. The garden and other facilities could be accessed easily.
- Sitwell ward had a patient admission that was unsuitable for that mental health ward. We saw where staff had accounted for this patient's disability and made immediate changes to the ward environment in order to support this patient's needs.
- Staff had 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. Food choices for religious and cultural needs were catered for.
- There was a chaplaincy service that provided spiritual support for patients from all faiths.
- Within the hospital patients could use a multi-faith room, visiting room or quiet area as a place to meet their spiritual needs. Staff took patients to an onsite chapel and provided information about faith when requested.

**Listening to and learning from concerns and complaints**

- The provider received seven complaints on Sitwell ward and one on Spencer North in the last 12 months. Three were upheld. No complaints were referred to the public

Good

# Wards for people with learning disabilities or autism

health service ombudsman. The provider had investigated the complaints to learn lessons, and had apologised when required in line with the Duty of candour.

- There were information posters displayed for patients to see how they could make a complaint. Complaint forms were easily accessible; we saw staff supported patients to complete these. There were information posters and easy read documents explaining patient rights.
- Patients said they know how to complain should they feel the need. However, some patients said they had complained about staff being rude and did not get any apologies.

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

Good

### Vision and values

- The provider had a vision of "transforming lives by building world-class mental healthcare services". The provider values were compassion, accountability, respect and excellence.
- The provider's vision and values were on display throughout the service and in their welcome pack. Staff were given these as part of their induction and knew the values when we asked. Some staff said they hoped to be making a difference and hold the values to heart.
- During the last comprehensive inspection in July 2016, some staff said senior management do not attend the wards and were unfamiliar with who senior staff were. During this inspection, some staff still did not know who some of the hospital senior managers were, and felt they were not visible on the wards.

### Good governance

- An electronic system allowed senior staff to monitor compliance rates with mandatory training. However, not all staff had completed mandatory training for Management of Actual and Potential Aggression (MAPA).
- We saw supervision logs, which showed staff had received managerial supervision monthly. The manager for Spencer North had kept some logs of discussed topics, such as patient cases, workload, staffing, development and training. Managers on Sitwell ward told us they were informed not to keep a log of discussions. Staff said there was no record to assure that performance, caseloads, training and managerial issues were discussed.
- Sitwell ward did not have a manager in post. One deputy was new in post and one unfamiliar with where managerial records were kept.
- Staff we spoke with were unclear as to why some new procedures had been implemented and how to implement them. 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.
- Managers completed clinical audits, such as incident records, patient care plans and prescriptions. These audits were then fed up to senior management. However, there was not a clear procedure in place for managers to audit patient seclusion records.
- Staff told us they thought the appraisal was a tick box exercise, they did not feel they had an opportunity for staff development in areas they chose.
- Some staff had been promoted into senior positions across both wards.
- Managers said they feel they have sufficient authority to do their job, they felt supported by seniors and encouraged to raise any issues.

### Leadership, morale and staff engagement

- The sickness rate for both wards was 4% for the last 12 months. Three staff were off on long term sickness, due to injury. Staff we spoke with said they had felt 'burn out' due to short staffing across wards.
- Staff were aware of the providers 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.
- We saw examples where staff had explained to patients when something went wrong. Managers said they encouraged staff to be open and honest.

### Commitment to quality improvement and innovation

Good

# Wards for people with learning disabilities or autism

- 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 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 accurate and complete seclusion records are kept.
- The provider must ensure staff complete appropriate physical checks and recording for patients in seclusion and following rapid tranquilisation.
- 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 seclusion and long term segregation policies meet the Mental Health Act code of practice and that staff are fully aware of terminology and required practice.

### Action the provider SHOULD take to improve

- The provider should consider all clinical and medical advice available before accepting new admissions.
- The provider should review the use of restrictions on forensic and rehabilitation wards to ensure they are following least restrictive practice.
- The provider should consider how the perception of bullying can be addressed.
- The provider should ensure staff are clear as to why new procedures are introduced and are supported with how to implement them.
- The provider should ensure handover records are kept in a clear location for staff to review.
- The provider should ensure staff record what is said in handovers.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>Seacole ward had outstanding maintenance issues. The heating was not working properly.<br><br>Staff and patients reported a smell of sewerage in the ensuite bathrooms of some rooms.<br><br>Sunley ward was not clean, bed linen was stained and smelly, and dirty linen was stored with clean linen.<br><br>This was a breach of regulation 15. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Staff did not complete the new seclusion record fully and the checklists were incomplete. Seclusion records were difficult to follow. We found this on all forensic wards and on Sitwell and Spencer North learning disabilities wards.<br><br>Policies for seclusion long term segregation and enhanced support were confusing and 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. Many staff described patients as being in 'extra care' when in fact they were either secluded or in long term segregation.<br><br>This was a breach of regulation 17. |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Low numbers of staff had received training in managing violence and aggression. Some staff trained in PMAV were out of date with training, due to low staffing levels managers could not be assured that there were enough trained staff on duty for each ward, or that these staff were experienced in use of restraint.

Staffing levels did not meet the required establishment level. There was no manager in place for Sitwell ward. The staffing establishment numbers were being met on some wards at the beginning of a shift but when there was a need for increased staffing because of observations or staff need to help out on other wards staffing levels were reduced because extra staff were not always found.

This was a breach of regulation 18.