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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Inadequate
Are services responsive?	Good
Are services well-led?	Requires improvement

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Ted Baker
Chief Inspector of Hospitals

Overall summary

Following our inspection, we issued a letter of intent informing the provider we were considering taking urgent action because of the immediate concerns we had about the safety of patients. We told the provider they must provide immediate assurance in relation to staffing levels, staff completing enhanced observations of patients in line with National Institute of Health and Care Excellence guidance and staff reporting incidents and appropriate action is being taken. We received the requested assurance.

We rated St Andrew's Healthcare Women's service as **inadequate** because:

- Safety was not a sufficient priority across the service. Staff did not always keep patients safe from avoidable harm whilst on enhanced observations on the forensic wards and on the psychiatric intensive care unit. Staff did not always follow the provider's policy and procedures on all wards on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. Patients alleged that staff on Sunley ward used inappropriate restraint techniques. Levels of restraint significantly increased since the last comprehensive inspection across the forensic service. Staff did not always record details of restraint techniques used.
- There were times when patients were not well supported and cared for. Staff did not always treat patients with kindness, dignity and respect. Staff at the forensic service used derogatory and inappropriate language to describe patients. Staff at the forensic and learning disability services misgendered patients. Staff at the long stay rehabilitation service did not always uphold patients' dignity in relation to medication and care.
- Managers had not ensured established optimum staffing levels on all shifts. The provider reported that 12% of shifts were unfilled between 01 February 2019 and 31 January 2020. The provider reported 13 forensic service failure incidents due to staff shortages between 01 September 2019 and 29 February 2020. Patients and staff told us that staff shortages often resulted in staff cancelling escorted leave, hospital appointments and activities across all cores services.
- We were concerned that staff were not reporting all safeguarding concerns to the local authority safeguarding team at the forensic and psychiatric intensive care services. Staff at these services were not reporting all incidents and not recording all incidents appropriately. Staff did not always follow the Mental Health Act Code of Practice in relation to seclusion, long term segregation and blanket restrictions. Staff were confused about what constituted long term segregation and the purpose of using long term segregation.
- Managers did not ensure safe and clean environments in the long stay rehabilitation service and learning disability service. Staff did not learn from cleanliness audits. Staff had not completed the Elgar ward ligature risk assessment. Facilities and premises used on Elgar

and Spring Hill wards were not appropriate for the service being provided. Staff failed to maintain reliable systems, processes and practice around medicine management. We found issues with inappropriate storage of medicines, staff not labelling opened medications, patient allergy information and a significant medication error.

- Patients were at risk of not receiving effective care and treatment. Staff did not always support patients' physical health needs effectively at the long stay rehabilitation and forensic services. We reviewed incidents where staff had not provided physical health interventions as required and staff did not always record patient's physical health or nutritional needs.
- Staff did not always share clear information about patients and any changes in their care. Staff in the forensic service did not always complete handovers in line with the provider's policy and procedures. We found examples of poor record keeping of handovers. Staff arrived late to handovers. Staff were not completing risk assessments on Elgar ward, with information being copied between records for different patients.
- Managers did not ensure all staff received appraisal and supervision at the forensic and learning disability services. Managers on the learning disability wards and forensic wards did not make sure staff received specialist training for their role.
- The leadership and governance did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed staff failures to follow the provider's procedures. Leaders did not always understand the issues, priorities and challenges the forensic and long stay rehabilitation services faced. We were not assured that leaders had taken sufficient action to address concerns raised during the focused inspection of the forensic service in January and February 2020 or addressed concerns of the same themes identified at other service inspections in St Andrews Healthcare.

However:

- Staff provided a range of care and treatment interventions suitable for the patient group. The teams included or had access to the full range of specialists required to meet the needs of patients on the ward. Teams held regular and effective multidisciplinary meetings.
- Staff supported patients to engage with the wider community. There was a chaplaincy service and access to spiritual leaders for other faiths.
- Senior leaders were visible across the location and were approachable for patients and staff. Staff told us that the chief executive officer visited regularly. Occupational health services and a trauma nurse supported staff physical and emotional health needs. The provider invested in a programme of support to promote staff well-being.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Safe- inadequate Effective - good Caring- requires improvement Responsive- good Well led- requires improvement
Forensic inpatient or secure wards	Inadequate	Safe- inadequate Effective - requires improvement Caring- inadequate Responsive- good Well led- inadequate
Long stay or rehabilitation mental health wards for working-age adults	Requires improvement	Safe- inadequate Effective - requires improvement Caring- requires improvement Responsive- requires improvement Well led- requires improvement
Wards for people with learning disabilities or autism	Requires improvement	Safe- requires improvement Effective – requires improvement Caring- inadequate Responsive- good Well led- requires improvement

Summary of findings

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Inadequate

St Andrew's Healthcare

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards; Long stay or 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 Women's service registered with the CQC on 11 April 2011. The Women's service is situated on the Northampton site. The other registered locations at Northampton are the adolescent's services, men's services, and neuropsychiatry services.

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

St Andrew's Healthcare Women's service consists of four core services and it has been inspected seven times.

St Andrew's Healthcare Women's service is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act

The service has a nominated individual and a registered manager.

This service was last inspected between January 2020 and February 2020. This was a focused inspection of Seacole ward in the forensic core service, carried out in response to concerns raised. We did not rate the service at this inspection.

We took enforcement action and issued a section 31 urgent notice of decision, imposing conditions on the provider for breaches of the following regulations:

Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment:

- Patients were at risk of continuing harm. The service did not always manage patient safety incidents well.
- Staff did not always act to prevent or reduce risks to patients and staff. Staff did not always keep patients safe from harm whilst on enhanced observations.
- Staff did not always follow the provider's policy and procedures on the use of enhanced observations when supporting patients assessed as being at higher risk harm to themselves or others.
- The service did not have enough nursing and support staff to keep patients safe.

Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance:

- The leadership, governance and culture did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations. There was no evidence that the provider undertook regular and effective audits of these issues.

We issued a requirement notice for breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment:

- The provider's board had not authorised the use of mechanical restraint, in line with guidance, and staff had not followed care plans in relation to the reporting and monitoring of mechanical restraint.

The last comprehensive inspection of the Women's service was carried out in May 2017. The service was rated as good overall. Safe was requires improvement, effective, caring, responsive and well led were rated as good. We found the following breaches:

Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance:

- 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.

Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

- 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 on other wards staffing levels were reduced because extra staff were not always found.

The following services were visited on this inspection:

Summary of this inspection

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

- Bayley ward is a psychiatric intensive care unit with 10 beds. Bayley ward opened in May 2017, therefore this inspection is it's first.

Forensic inpatient/secure wards:

- Seacole ward is a medium secure ward with 15 beds. The ward was in the process of closing during the inspection and the provider has since advised it is closed. Most patients have been transferred to Sunley or Stowe wards.
- Stowe ward is a blended low/medium secure ward with 13 beds.
- Sunley is a medium secure ward with 14 beds.

Long stay / rehabilitation wards for working age adults:

- Spring Hill House is a dialectical behaviour therapy (DBT) unit with 23 beds.
- Spencer South, Spencer House is a locked rehabilitation and dialectical behaviour therapy ward with 14 beds.
- Hereward Wake is a locked rehabilitation and dialectical behaviour therapy ward with 12 beds.
- Sinclair ward is a low secure ward with 15 beds.
- Thornton ward is a locked rehabilitation ward with 15 beds.
- Elgar ward is a low secure ward with 12 beds.

Wards for people with learning disability or autism:

- Sitwell ward, a medium secure service for women with learning disabilities and /or autistic spectrum conditions with 13 beds.
- Spencer North ward, a low secure service for women with learning disabilities and/or autistic spectrum conditions with 12 beds.
- Billing Lodge, a step-down service for women with learning disabilities and/or autistic spectrum conditions with three beds.

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

We found the provider had not addressed all the issues from previous inspections. Details can be found in the report.

Our inspection team

The team that inspected the service comprised one inspection manager, eight CQC inspectors, one CQC assistant inspector, two Mental Health Act reviewers, eight specialist advisors, including nurses, occupational therapists and social workers, and two experts by experience.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. We brought this inspection forward due to an increase in concerns in relation to staffing levels and safe care and treatment of patients we were receiving through our monitoring processes. Concerns related to patient safety and the running of the service.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Summary of this inspection

During the inspection visit, the inspection team:

- visited all 13 wards, including an evening visit to the forensic wards, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 56 patients who were using the service
- spoke with senior leaders and managers or acting managers for 11 wards
- spoke with 93 other staff members; including doctors, registered nurses, occupational therapists, psychologists, support staff, speech and language therapists, social workers, rehab support workers, peer support workers, ward administrators and domestic staff
- attended and observed six care activities and 12 multi-disciplinary meetings
- looked at 55 care and treatment records of patients and 50 seclusion records
- carried out a specific check of the medication management on all wards
- facilitated three focus groups for staff
- 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 56 patients.

At the psychiatric intensive care unit, we spoke with four patients. All patients reported negative experiences about the ward. Three patients felt they could not tell us anything positive about their experience. All patients raised concerns about being on the ward at night. They told us the ward was often noisy and that night staff did not treat them well. They reported being threatened with restrictions if they did not do as they were told, examples included not being given hot drinks. Overall, patients did not feel that there were enough staff on the ward. They told us that it was rare to see a doctor on the ward during the week. However, although they felt staffing levels were not high enough, they did tell us they had access to leave and activities. Three patients felt they should be more involved in their care and told us they were not involved in creating their care plan. Three patients felt staff were ‘heavy handed’ when they restrained patients. Patients felt staff were helpful when they approached them, but three patients said staff could be more engaged with patients in general and that interactions were often brief. Three patients raised issues with the cleanliness of the environment and told us it was not cleaned often enough for it to be a pleasant place to live. Patients told us there could be more variety with the food choices.

At the forensic service we spoke with 13 patients. On Sunley ward we spoke with seven patients. All patients reported negative experiences including five patients reporting that three particular staff members used inappropriate restraint techniques that caused pain. All patients told us that there were not enough staff and appointments, activities and leave were often cancelled. All patients told us there were lots of different agency and bank staff on the ward. Some patients found it difficult when there were a lot of male agency staff on duty. All patients told us there were not enough activities. Four patients described incidents when staff had spoken to them in a derogatory manner, for example telling them to “sort themselves out” when engaging in self harm behaviour. Three patients told us that they did not feel safe. Three patients told us they were not involved in decisions about their care. Two patients told us that their planned psychology sessions had not taken place. However, patients told us that there were some good, lovely staff. On Stowe ward, we spoke with four patients who were positive about their experience of the ward. Patients told us that the care was wonderful, staff were lovely and helpful, they were involved in their care and treatment plans, they felt safe and their leave took place as planned. On Seacole ward we spoke with two patients, one was positive about their experience on the ward and the other was unhappy about the time it took to respond to complaints. All patients told us they had access to advocacy and that the food was alright.

At the long stay / rehabilitation wards for working age adults we spoke with 29 patients. Some patients on Spring Hill ward 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 when staff cancelled their section 17 leave, they felt upset and

disappointed as they had worked hard to get their leave. Some patients told us there was a lot of temporary staff out of hours. Patients spoke about the many restrictions around vaping times, access to the garden courtyard, snacks, and hot and cold drinks. One patient on Spring Hill ward said the alarms repeatedly go off for staff to respond to. Patients were distressed and witnessed other patients in distress whilst trying to recover and didn't feel safe. Two patients on Elgar ward told us there were not enough staff to provide activities or go off ward to Tomkins café. Patients said they would like staff to be more cooperative and polite. One patient on Elgar ward said patients were often screaming, swearing and staff are unable to manage this. Another patient on Elgar ward told us staff "forgot to wake her" in the morning and she felt because of a protected characteristic she was cared for less favourably and left till the end. Three patients on Hereward Wake told us the ward was not kept clean and sanitary dispensers and waste bins were not regularly emptied. They said staff were generally kind and dialectical behaviour therapy was helping them. One patient from Thornton ward said the psychiatric medicines were helping but mainly the psychological therapy was making a difference. Staff made her feel safe, they helped her with panic attacks and to process abuse.

At the wards for people with learning disability or autism we spoke with ten patients. Patients told us staff did not always treat them with kindness, dignity and respect. Four patients described some staff as being rude, ignorant and abrupt. One patient told us staff called her an attention seeker. One patient told us staff do not interact with her when they were observing her on her enhanced observations. One patient told us staff interact with each other in a different language which she doesn't understand. Two patients told us staff fall asleep on their enhanced observations. One patient said she felt that not all staff cared about her. One patient told us staff would not give her toilet roll when requested. Two patients told us they do not feel safe. Three patients described the wards as being noisy. Seven patients told us the wards were short staffed. However, five patients told us they feel safe on the wards. Four patients told us staff were kind. Three patients told us staff were respectful.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- Safety was not a sufficient priority. Managers had not ensured established optimum (ideal) staffing levels on all shifts. The provider reported that 12% of shifts were unfilled between 01 February 2019 and 31 January 2020. This was highest in the learning disability service which reported 16% unfilled shifts, followed by 15% at the forensic service and 13% at the psychiatric intensive care unit. The provider reported 13 forensic service failure incidents due to staff shortages between 01 September 2019 and 29 February 2020. Patients and staff told us that staff shortages often resulted in staff cancelling escorted leave, hospital appointments and activities across all cores services.
- Staff did not always keep patients safe from avoidable harm whilst on enhanced observations. Between 01 September 2019 and 29 February 2020, the provider reported 798 incidents of patients' self harming whilst on enhanced observations on the forensic wards and 30 on the psychiatric intensive care unit.
- Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. We found issues on all wards. We found examples of staff not completing observation records. We found shift leads allocated staff to complete enhanced observations for up to 12 hours, without a break. Shift leads allocated staff to key safety roles and patient observations at the same time.
- We found staff applying blanket restrictions on forensic, long stay rehabilitation and learning disability wards. These included no access to bedrooms and toilets, outdoor courtyards locked all day, restricted toilet paper, restricted vaping times and access to snacks and hot and cold drinks.
- Patients alleged that staff on Sunley ward used inappropriate restraint techniques. Five patients told us that three staff used inappropriate restraint techniques whereby they bent the patient's wrist and arm behind their back. We reported this immediately to the provider.
- Levels of restraint significantly increased since the last comprehensive inspection. The provider reported 1,198 incidents of restraint across the forensic core service between 01 September 2019 and 29 February 2020. Staff did not always record details of restraint techniques used.

Summary of this inspection

- Staff did not always follow the Mental Health Act Code of Practice in relation to seclusion and long term segregation. Doctors, nurses and multidisciplinary teams were not always completing reviews as required. Staff had not always contacted families, carers or advocacy when a patient was secluded. Carers or family were not involved in the decision to use segregation. Staff did not complete all hourly observations for patients in long term segregation. Staff were confused about what constituted long term segregation and the purpose of using long term segregation.
- We were concerned that staff were not reporting all safeguarding concerns to the local authority safeguarding team at the forensic and psychiatric intensive care services. Staff at these services were not reporting all incidents appropriately. We observed three incidents during our visit which staff did not report on the providers incident system until prompted by our team.
- Staff failed to maintain reliable systems, processes and practice around medicine management. We found issues with inappropriate storage of medicines, staff not labelling opened medications and patient allergy information not being easily available. A significant medication error occurred on Sinclair ward in the long term rehabilitation service, where one patient did not receive 52 doses of their prescribed medication which led to a deterioration in their mental state.
- Managers did not ensure safe and clean environments in the long stay rehabilitation service and learning disability service. Managers failed to maintain the quality, cleanliness, upkeep and safety of Spring Hill, Elgar and Sitwell ward environments. Staff did not learn from cleanliness audits. Staff had not completed the Elgar ward ligature risk assessment for the garden courtyard to risk assess it was safe for patient use. Although the ligature risk assessment on Sitwell ward was in date, it was not current with least restrictive changes that had been made to the ward. We observed mixed bags of unlabelled laundry on Sitwell ward, this issue had been highlighted in the last three cleanliness audits.
- Managers and staff at the long term rehabilitation service failed to provide access to health care and specialists at the right time for three patients on Sinclair and Elgar wards.
- Staff were not completing risk assessments on Elgar ward, with information being copied between records for different patients.

However:

- Staff received feedback from investigation of incidents via 'red top alerts' sent by email. Staff gave examples of changes made following incidents. Staff spoken with said they were debriefed and received support after a serious incident.
- Staff received and were up to date with mandatory training.

Are services effective?

Requires improvement

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

- Staff did not always support patients' physical health needs effectively. We reviewed two incidents on the forensic wards where staff had not provided physical health interventions as required. Staff at the long term rehabilitation service did not always record patients' physical health or nutritional needs and there were delays in patients accessing treatment and staff responding to medical emergencies.
- Staff did not always share clear information about patients and any changes in their care. Staff did not always complete handovers in line with the provider's policy and procedures. We found examples of poor record keeping of handovers. Staff arrived late to handovers.
- Managers did not ensure all staff received appraisal and supervision. Between 01 August 2019 and 31 January 2020, the average clinical supervision rate across forensic wards was 73%. Between 01 August 2019 and 31 January 2020, the average appraisal rate across forensic wards was 54%. For the learning disability service supervision rates across all wards was 57%.
- Staff did not always maintain good standards of documentation for patient care at the long term rehabilitation service and learning disability service. We found staff did not always complete a comprehensive mental health assessment, care plans and capacity assessments for all patients.
- Not all staff at the long stay rehabilitation service were able to access regular team meetings due to pressures on the ward.
- Managers on the learning disability wards and forensic wards did not make sure staff received specialist training for their role including learning disability, autism training or transgender training.

However:

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and delivered in line with, guidance from the National Institute of Health and Care Excellence. Interventions included dialectical behavioural therapy programme, 'reinforce appropriate implode disruptive' approach, work on psycho-social skills and trauma work.

- The teams included or had access to the full range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, teams included or could access occupational therapists, physiotherapists, clinical psychologists, social workers, pharmacists and dieticians. Staff had the right experience, qualifications, skills and knowledge to meet the needs of the patient group. Teams held regular and effective multidisciplinary meetings.
- Staff used recognised rating scales to assess and record severity and outcomes. Managers participated in clinical audit, benchmarking and quality improvement initiatives.

Are services caring?

Inadequate

We rated caring as **inadequate** because:

- Staff did not always treat patients with kindness, dignity and respect. We observed Sunley staff describing patients as 'self harmers'. Sunley patients described incidents of staff making derogatory remarks, including being told to "sort themselves out" when engaging in self harm behaviour. Staff on Sunley reported that colleagues used inappropriate language to describe patients, for example; "kicking off" "attention seeking". On Sunley ward we observed a staff member responding to a patient who approached them say "I'm not on shift yet". Seacole staff recorded that a patient must go without a shower and stay in pyjamas all day. In the psychiatric intensive care service, staff described patient's behaviour in seclusion as 'new tricks'.
- Staff on Sunley and Sitwell wards misgendered patients. We reviewed records of a Sunley patient who identified as male. Their notes clearly stated that they wished to be referred to using male pronouns, however we viewed a referral letter to the local acute hospital that referred to the patient as 'she'. We reviewed records for a patient on Sitwell ward who identified as male. Staff misgendered the patient throughout their care and treatment record and referred to them by their previous female name. The provider's 'Trans inclusion' policy states "The continual use of incorrect names or pronouns is known as misgendering. This has significant impact on the individual and the perpetrator can be prosecuted as part of the Equality Act 2010 as it is acknowledged as a Hate Crime."
- On Elgar ward we observed poor interaction with patients with staff sitting on window ledges twiddling keys. Staff on Elgar and

Spring Hill ward did not uphold patient's privacy and dignity when administering medicines through a wooden hatch. Staff on Elgar ward did not maintain a patient's dignity, when they were naked in a communal area.

- Staff did not always keep families or carers informed and involved.

However:

- We saw examples of staff kindness and sensitive support. We observed staff on Hereward Wake ward caring for one patient after a "difficult" nasogastric tube feed and provided after care support with a hand massage. Patients on Stowe ward were positive about staff on the ward and told us that staff treated them well and behaved kindly.
- Staff involved patients in decisions about the service, when appropriate. The provider introduced a new recruitment process, which involved patients interviewing candidates. Patients could give feedback on the service and their treatment and staff supported them to do this. We observed two ward rounds and one discharge care programme approach meeting and staff involved patients. Patients chaired weekly community meetings on all wards.

Are services responsive?

Good

We rated responsive as **good** because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- Patients were supported to engage with the wider community. A patient on Seacole ward set up dog sponsorship for the ward and led on fund raising activities for a dog rescue charity.
- Managers on Sinclair ward provided two patients who were deaf with signers to support them.
- There was a chaplaincy service and access to spiritual leaders for other faiths.

However:

- Staff did not treat all complaints seriously. We reviewed records of one patient in the forensic service who told us they had complained about staff neglect and attitude. We found three references to the patient wishing to complain but no further information or follow up actions. Managers at the learning disability service did not always respond to patient or carer complaints in a timely or effective manner.

Summary of this inspection

- Facilities and premises used on Elgar and Spring Hill wards were not appropriate for the service being provided. However, the provider advised that they had assessed this and were planning to address through a programme of ward moves and refurbishment.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- The leadership and governance did not always support the delivery of high quality, person centred-care. The providers governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations, handovers, ward cleanliness and safety of ward environments in the forensic and long stay rehabilitation services. There was no evidence that the provider undertook regular and effective audits of these issues. We were not assured that the provider acted to ensure staff followed the enhanced observations procedure when supporting patients assessed as high risk of self harm.
- Leaders did not always understand the issues, priorities and challenges the forensic and long stay rehabilitation services faced. We were not assured that leaders had taken sufficient action to address concerns raised during the focused inspection of the forensic service in January and February 2020. Leaders were reactive rather than proactive in their response to issues. Leaders had not ensured staff in the forensic service were reporting all incidents or that relevant incidents were reported to the local authority and notified to CQC.
- Governance systems were not effective in ensuring shifts were covered by sufficient numbers of staff of the right grade and experience. The provider reported that 12% of shifts were unfilled between 01 February 2019 and 31 January 2020.
- Managers in the long stay rehabilitation service failed to feed back the outcomes and findings from incidents and complaint investigations to staff, through regular team meetings and communications.

However:

- Senior leaders were visible across the location and were approachable for patients and staff. Staff in the forensic service told us that the new operational lead and clinical leads for the service were visible on the wards. Staff told us that the chief executive officer visited regularly.
- Occupational health services and a trauma nurse supported staff physical and emotional health needs. The provider

Summary of this inspection

invested in a programme of support to promote staff well-being. The provider recognised staff success within the service through staff awards. The provider issued awards based on their values on a monthly and quarterly basis, which then culminated in an organisation wide annual awards ceremony for the overall winners.

- Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.
- The service had business continuity plans to manage emergency situations, for example, adverse weather events and influenza pandemics.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. However, staff did not always follow the Mental Health Act Code of Practice in relation to seclusion, long term segregation and the application of blanket restrictions.

As of 29 February 2020, 94% of the workforce in this service received training in the Mental Health Act.

The training compliance reported during this inspection was higher than the 75% reported at the last inspection.

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 staff applied the Mental Health Act 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.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

We found that managers and staff on Spring Hill ward were confused about what constituted long-term segregation. Staff described patients as being in 'extra care' when in fact they were in long-term segregation.

Patients across the location could access the Independent Mental Health Advocacy service. An independent advocate is specially trained to support people to understand their rights under the Mental Health Act and support patients with decisions about their care and treatment. Patients had access to advocacy and independent mental health advocates based on the provider's site for support with complaints and tribunals.

We reviewed consent to treatment documentation and found medicines were prescribed in accordance with the provisions of the Mental Health Act. We found that the legal certificates authorising treatment for mental disorder for detained patients were kept with the medicine chart as required by the Mental Health Act Code of Practice. This meant that staff administering medicines could check that they had the appropriate paperwork and legal authority to give medication to detained patients at the time the medicine was given. The only exception was on Sinclair ward for consent to treatment audits. On Sinclair ward a peer review audit dated 03 March 2020 for consent to treatment identified that five patient records were not completed. We checked if these issues had been actioned at 3.30pm the following day 04 March 2020 but they remained outstanding.

The service did not accommodate informal patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles.

As of 29 February 2020, 94% of the workforce in this service received training in the Mental Capacity Act.

The training compliance reported during this inspection was higher than the 75% reported at the last inspection.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

There were no Deprivation of Liberty Safeguard applications made in the last six months.

Detailed findings from this inspection

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

For patients who might have impaired capacity, staff mostly assessed and recorded capacity to consent appropriately. When a patient did lack capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture, and history. However, on Elgar ward staff had not completed capacity assessments or best interest forms for three out of six patients in relation to specific decisions.

The multi-disciplinary 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. Most care plans reflected patient views around medication, interventions and decisions.

Overview of ratings

Our ratings for this location are:

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

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

Requires improvement

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

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

Inadequate

Safe and clean environment

Staff kept wards safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff assessed environmental risks regularly and recorded ways to mitigate those risks, this included assessing ligature risks (a ligature risk is something in the environment that a patient may be able to use to cause harm to themselves by strangulation). The layout of the ward allowed for clear observation of patients, although the perspex windows on the nursing office were very scratched in places.

Staff admitted female patients only to Bayley ward. Staff carried personal alarms and patients had access to nurse call systems in their bedroom if they required assistance.

The service displayed handwashing posters on the ward and records demonstrated that housekeeping staff cleaned the ward regularly. However, there was no alcohol gel available to staff on the ward to further support infection control principles.

The seclusion room contained appropriate furniture and was clean. Patients using the room could orientate themselves to time via the clocks in view. Staff spoke to patients through an intercom system and staff could adjust the temperature of the room to the patient's preference. Staff identified ligature risks in the seclusion room in the ward ligature risk assessment and recorded ways to mitigate these.

The extra care area of the ward (an area where patients with high support needs may be nursed away from the main ward) had a separate bedroom, bathroom and lounge area. The extra care suite was clean and well maintained. A chair was seen to be worn and presented a potential infection control risk, however staff made us aware that managers had ordered new ones.

Staff equipped their clinic room with accessible resuscitation equipment and emergency drugs that they checked regularly. Staff recorded the room thermometer as broken on 29 February 2020 and ordered a replacement on 1 March 2020. Prior to this, staff recorded the temperature of the clinic room regularly to ensure this supported the efficacy of medication kept in the room. Staff maintained equipment well and kept it clean. They displayed 'clean' stickers showing the date they cleaned equipment. Staff undertook weekly 'clinic room checks' to ensure standards of cleanliness, appropriate medication storage and the maintenance of equipment.

Safe staffing

The ward had an establishment of ten whole time equivalent (wte) registered nursing staff and 26 wte healthcare support workers.

At the time of the inspection the manager had vacancies for four wte registered nursing staff. All vacancies had been appointed to and were in recruitment process. The manager also had vacancies for six wte healthcare support workers. Two vacancies had been appointed to and were in recruitment process.

From February 2019 – January 2020 of 5030 shifts on Bayley ward, Managers filled 3905 with permanent staff, 11 with agency staff and 447 with workchoice staff. Workchoice is an internal bank of staff managed by the provider.

Managers did not fill 668 shifts. Across the shifts for the 12 months this equated to 2% agency use, 9% workchoice use and 13% of shifts unfilled. The provider advised that data for shifts were based on optimum (ideal) numbers.

Shifts planned required three registered nursing staff on shift during the day and two at night. We reviewed staffing rotas from November 2019 – February 2020. In November there were four occasions where one nurse was on duty during a night shift. In December there was one occasion where there was one nurse on duty for night shift, one occasion where one nurse was on duty during a day shift and one example where there were no nurses recorded on duty during a night shift. In January 2020 there were four occasions where one nurse was recorded on duty on night shift. In February 2020 there was one example of one nurse on duty at night and one example of one nurse on duty during the day.

Managers used regular workchoice and agency staff where possible. Managers block booked the same staff up to two months in advance, to support continuity of care for patients.

From March 2019 – February 2020 the average turnover rate for staff was 11% and the average rate of sickness was 4.5%.

Staffing levels did not always meet the level required to support staff carrying out their duties. On the day of inspection, staff allocated observations in a way that did not meet policy. One staff member was allocated to three consecutive hours of enhanced observations. One member of staff was allocated to two separate periods of enhanced observations but was also allocated to be the responder for the shift. This meant there was potential for the staff member needing to leave their observations to attend to incidents. Managers allocated tasks per shift using the whiteboard and this was changed every shift. There were no paper records of previous shift allocations.

Managers planned shifts in a way that considered the gender mix of the staff team. If gender mix became an issue, through staff unplanned absence, managers contacted the bleep holder to arrange for staff to be moved from other wards.

The service had access to enough medical staff to meet the needs of the patients. A duty rota was in place for any out of hours support required.

Staff received and were up-to-date with appropriate mandatory training. Overall, staff in this service had undertaken 97% of the various elements of training that the provider set as mandatory. The provider reported 93% for basic life support, 95% for intermediate life support, 98% for level two safeguarding adults and children and 94% for management of actual and potential aggression training. There were no mandatory courses with a compliance rate below 75%.

The mandatory training programme was comprehensive and met the needs of staff.

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

Assessing and managing risk to patients and staff

We looked at six out of ten care and treatment records.

Staff completed a risk assessment with patients on admission to the service. Staff recorded information about historical risks and current risks. When risk changed, staff updated the risk assessment.

Staff created risk management plans and additional care plans to support patients with specific risk issues.

We looked at 15 examples of patient observation records. Staff did not always follow best practise in relation to patient observations. The National Institute for Health and Care Excellence recommend that staff should not be allocated to enhanced observations for more than two consecutive hours due to the potential risk of tiredness and the ability to concentrate (NG10). We found 13 examples of staff allocated to longer than two hours of enhanced observations. The longest example we found was a member of staff allocated to enhanced observations for six continuous hours, three times the maximum length of time recommended by National Institute for Health and Care Excellence.

Staff recorded 30 incidents of patients self harming whilst subject to enhanced staff observations between August 2019 and February 2020. The highest number being eight, in October 2019.

Staff adhered to the service policy when searching patients.

The provider implemented a smoke free policy across the site. Staff restricted patients use of electronic smoking devices to allocated times. Patients could not use these devices as a nicotine replacement therapy freely. The

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

Requires improvement

providers policy for electronic cigarette use informed staff patients could access this up to six times per day. Staff displayed seven times slots for 'vaping' and allocated patients to these slots. Based on the information displayed, patients did not have access to six slots per day. The service did offer other forms of nicotine replacement therapies. The provider told us they would allow patients to use electronic smoking devices outside of allocated times when possible and safe to do so.

All patients on the ward were detained under the Mental Health Act.

From February 2019 – February 2020 staff recorded 249 incidents of seclusion. The highest amount being 34 in January 2020. The average time a patient spent in seclusion was 35 hours (2074 minutes). The shortest time recorded was 50 minutes and the longest was 371 hours (15 days).

We completed a detailed review of five seclusion records relating to Bayley ward. Two examples did not evidence two hourly nursing reviews took place in line with the Mental Health Act Code of Practice. One record did not evidence continuing medical reviews took place every four hours and one record did not evidence an independent multidisciplinary review took place when required. One seclusion care plan did not include a plan describing how staff should meet patient need, how best to de-escalate and how to manage risk.

Between February 2019 and February 2020 staff recorded 14 episodes of long term segregation.

We reviewed one record of long term segregation. This record was reviewed on the second day of long-term segregation. Although the notes about why long-term segregation was used included a statement that the patient had an irritable and hostile reaction with peers, the main focus of the decision was about risk from others. It was noted that the patient responded better to in a low stimulus environment. There was no record of recent assaultive behaviours in the patient's progress notes. This does not meet the guidance for the use of long-term segregation in the Code of Practice (26.150). The patient's parents were informed of the patient being put into long-term segregation but there was no evidence in the long-term segregation record that they had been involved in the decision. There was no involvement of an independent mental health advocate in the decision.

Between February 2019 and February 2020 staff recorded 497 incidents of restraint. Staff recorded 29 of these as prone (face down) restraint. Of the 29 prone restraints, 17 resulted in staff administering rapid tranquilisation.

Safeguarding

Ninety eight percent of staff completed safeguarding level one and two training. All staff completed safeguarding level three training. Staff described how they reported and identified safeguarding issues. Staff gave examples of working closely with the ward social worker for support and referrals and gave examples of working with external agencies to protect patients from abuse.

In the last six months staff made 257 safeguarding referrals. Two related to accident and injury, 27 related to allegations of abuse by staff, one related to loss and theft, 190 to physical aggression and violence, four to physical health, five to self harm, two to environmental failure, 13 to inappropriate activity and 13 to verbal aggression.

Staff access to essential information

Staff recorded information about patient care on an electronic system. We were not assured all information was present and up to date, based on the issues we identified with incident reporting. This included accuracy of incident reports and staff not recording incidents that should be reported.

All staff at St Andrews Healthcare used the same electronic system, therefore staff had access to information if patients moved between wards and services across the provider. Workchoice and agency staff had access to the electronic system.

Medicines management

Staff followed good practice in medicines management; transport, storage, medicines reconciliation, recording and disposal and did it in line with national guidance. However, staff did not have easily accessible information available to them about the legal framework under which they were dispensing medication. Staff did not record the status of the patient on medication records (whether they were under section or informal). Staff did not record the date a patient's section commenced or whether the patient was under a T2 or T3 (a T2 is where a patient is able to give consent to the prescribed medication, a T3 is a certificate completed where a patient cannot/will not consent and

has been put in place by second opinion approved doctor). Staff kept paper copies of the T2 and T3 in the nursing office and not with medication charts, so this was not readily available to staff dispensing the medication.

Staff reviewed the effects of medication relating to patients' physical health regularly. They did this in line with National Institute of Health and Care Excellence guidance and particularly when patients received high doses of antipsychotic medication.

Track record on safety

Between February 2019 and February 2020 staff reported five incidents classified as serious incidents. Three related to security, one to an accident and one related to self harm. The service had closed four of the investigations as completed. The incident relating to self harm remained open. Staff reported the self harm incident on 10 December 2019. Managers recorded the final report as due on 3 April 2020. Staff took immediate action to mitigate the risk to the patient, but the governance and investigation of the incident did not meet the timelines in the policy.

Reporting incidents and learning from when things go wrong

Staff did not report all incidents that should be reported. We found three examples during the inspection relating to the reporting of incidents.

We witnessed a restraint during the inspection, and this was not reported on the electronic system until it was requested by us 48 hours later. An allegation of abuse made by a patient was not recorded on the electronic system and was added retrospectively, seven calendar days post incident, following us raising this with a member of staff. Staff did not record a patient disclosure of a safeguarding nature as an incident, although in progress notes staff did record immediate actions and measures taken to reduce the risk to the patient.

When reviewing investigations, we noted that investigating staff used information in progress notes, along with staff and patient interviews, to establish when and if certain events took place. For example, if a patient reported they were harmed during a restraint, the Investigator reviewed notes for the day to see if a restraint took place. If there was no record of restraint the allegation was closed as unsubstantiated. However, we were concerned that staff did not always record accurate notes, based on the three issues we found during one day of inspection.

The provider issued 'red top alerts' following incidents to share learning across all locations. Managers explained how they shared lessons in team meetings and described improvements in documentation that had taken place following learning from previous provider wide inspections.

Staff had access to debriefs following incidents and could also access support from the trauma nurse service, if required.

Staff described their responsibilities relating to Duty of Candour.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed six out of ten care and treatment records.

Staff completed a comprehensive assessment of a patient's mental health in a timely way on admission. Staff included an assessment of the patient's physical health.

Staff created care plans which met the needs of the patient that they identified during the assessment. Care plans addressed a variety of different needs including physical health, mental health and relationships. Staff created additional care plans as and when required, to support patients with their changing needs. We saw additional care plans for weight management, support with eating and mental health medication administered by injection (depot). Staff updated care plans on a monthly basis, or sooner if required.

Best practice in treatment and care

Staff provided a range of activities and interventions to patients to support their recovery.

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

Requires improvement

Staff ensured patients had access to services that supported them with any ongoing physical health concerns. We saw examples of dieticians and physical health staff being referred to for specialist advice and support.

Patients could access all the services provided on site, if required. This included chaplaincy and appointments to see a general practitioner.

Staff worked with patients regarding diet and lifestyle. We saw examples of obesity being addressed through advice and support about food and staff encouraging patients to choose healthy options. We saw examples of staff supporting patients to eat and drink enough food to ensure their safety. Staff used food and fluid charts to monitor patient's food and drink intake where this was recorded as a risk.

Staff used recognised rating scales to assess and record severity and outcomes. These included Health of the Nation Outcome Scales, the Short Term Assessment of Risk and Treatability, Recovering Quality of Life, Simple Physical Activity Questionnaire and the Clinical Global Impressions scale.

Skilled staff to deliver care

Patients had access to a wide range of skilled staff to support their treatment. The team on the ward included; doctors, nursing staff, occupational therapy, a social care assistant, pharmacist, activity co-ordinator and a technical instructor. The ward shared a senior assistant psychologist with another ward and had access to a qualified psychologist one day per week.

Staff had experience and had the skills required to support patients effectively. The ward manager described the team as 'stable'.

From August 2019 – January 2020 80% of registered nursing staff and 77% of healthcare support workers received clinical supervision.

Managers described giving staff managerial supervision every three months.

Staff had access to reflective practise every Wednesday during the time the patients' community meeting took place. Staff described that ward dynamics sometimes affected their ability to attend. Managers kept a register of those who attended reflective practice.

All staff received an appraisal of their work and performance.

Multi-disciplinary and inter-agency team work

The provider was in the process of introducing structured 'daily huddle' meetings across their locations. The meetings had a set agenda of items for discussion including: reviewing 24 hours of incidents, safeguarding, complaints, serious incidents, seclusion and prone restraint, checking quality of safety nurse checklists, checking staffing allocation for enhanced support and reviewing safe staffing levels.

Managers did not hold regular ward team meetings. Records demonstrated that meetings took place on 10 November 2019, 16 November 2019, 16 February 2020 and 1 March 2020. The records indicated meetings took place during the day. There were no records of meetings held with night staff.

Staff shared information about patients at handover meetings within the team. Handovers took place at the beginning of each shift.

Ward staff had good working relationships with other teams across the provider and with external services. Staff recorded contact with a variety of professionals who supported the patients.

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

Ninety six percent of staff completed online training relating to the Mental Health Act.

Staff knew who the Mental Health Act administrators were and used their support when necessary. The provider had policies and procedures in place that reflected current guidance and staff had easy access to the policies and procedures via the intranet. Staff had access to electronic versions of the Mental Health Act Code of Practice. However, staff did not always follow the Mental Health Act Code of Practice in relation to seclusion, long-term segregation and the application of blanket restrictions.

Patients described how they could access independent mental health advocacy and told us that advocates visited the wards. Staff provided information about advocacy to patients in their admission handbook.

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

Requires improvement

Staff explained patients' rights to them regularly and in a way they could understand. If patients refused to have their rights explained or did not understand, staff recorded this.

Staff supported patients to take Section 17 leave (permission for patients to leave the hospital) and notes from multidisciplinary meetings showed that staff continually reviewed the amount and frequency of patients leave.

Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff stored relevant Mental Health Act paperwork in the nursing office. This included Section 17 leave forms. Staff had easy access to relevant forms as and when they needed them.

The provider monitored compliance with the Mental Health Act through audits completed on the wards.

Good practice in applying the Mental Capacity Act

Ninety six percent of staff completed online training relating to the Mental Capacity Act.

Staff described the principles of the Mental Capacity Act and how they applied this to their work.

Staff received training in (DoLS) as part of their Mental Health Act and Mental Capacity Act training. Staff had not made any deprivation of liberty safeguards applications in the last six months.

The provider has a policy on the Mental Capacity Act, and this included information about DoLS. Staff accessed the relevant policy and associated procedures on the intranet.

Staff knew who to access for support if they had concerns or queries relating to the Mental Capacity Act. Staff took all practical steps possible to support patients in making decisions about their care. Where patients did not have the ability to do this, staff made decisions in their best interests, considering their wishes, culture and history.

The provider monitored adherence to the Mental Capacity Act through audits completed on the ward. Staff acted based on the outcomes of audits and applied lessons learnt.

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

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Most staff demonstrated behaviours towards patients that were discreet, respectful and responsive to patient need. However, we were concerned by some of the language in seclusion records that described patients' behaviour as 'new tricks' and the minimising of patients' feedback about their feelings and concerns. Staff recorded information that was judgemental and not a factual account of the patient's time is seclusion.

Patients said that staff working during the day treated them well, respected their wishes and helped them with their needs. However, patients did not provide the same feedback for staff working night shifts. They said night staff 'shouted', made 'threats' to patients, were 'not very nice' and did not carry out night checks discreetly.

Staff described the needs of individual patients and records demonstrated they supported them to manage their care and treatment. Staff directed patients to other services, where appropriate, and supported them to attend other services, if required. We saw examples of this with dental and podiatry appointments.

Involvement in care

Staff had access to an admission leaflet that provided patients with information about the ward when admitted. This included information about; the team, contraband items, access to money, access to leave and meal times along with other information.

Patients described ways they gave feedback about the service and how they expressed their views. This included in one to one sessions and in ward community meetings. Two patients could not describe the contents of their care plan and did not have a copy of it. Two patients described the reasons for their admission and their rights under section.

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

Requires improvement

Staff invited patients to take part in their clinical review meetings. Records showed patients attending the meetings, making requests and reviewing their progress with the clinical team.

Staff did not record when they contacted families and carers when a patient required seclusion. We reviewed 19 episodes of seclusion, relating to eight patients and staff had not recorded how they had contacted family to make them aware of the seclusion, the section on the seclusion form was blank. Staff had not recorded any family contact information in progress notes during the time of the seclusion.

There was a carers centre located on site and one patient told us that the service supported their parent to visit by provision of accommodation and travel expenses.

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

(for example, to feedback?)

Access and discharge

From February 2019 – February 2020 Bayley ward reported an average bed occupancy of 90%. For the same time period, the average length of stay for patients was 41 days.

St Andrews Healthcare accepted referrals from across the country.

Admission assessments demonstrated that admissions took place at an appropriate time.

Staff worked with teams from the patient's local areas to plan discharge in advance. We saw examples of staff supporting patients to continue contact with their home teams and to be involved in their discharge planning. Staff completed discharge plans with all patients receiving treatment at the time of the inspection.

The facilities promote recovery, comfort, dignity and confidentiality

The ward environment provided sufficient space for patients to engage in activities and there was a full range of equipment and rooms to support other aspects of treatment and care.

Staff provided secure areas for patients to store their possessions and the service provided appropriate places where patients could meet visitors.

Patients had access to outside space. At the time of the inspection staff kept the doors to the outside area locked due to the temperature. Staff told us this would not be the case in warmer temperatures. Staff unlocked the door at patient request, this included unlocking the door when patients were due their allocated time to use electronic cigarettes.

Patients had access to their own mobile phones, if risk assessed as safe to. If risk assessed as not safe, staff supported patients to make phone calls in private using the ward facilities.

Patients told us the food was of good quality and they had choice. The ward provided options for patients that had dietary needs and preferences. Staff were trialling the use of hot water flasks in the communal area to support patients accessing hot drinks without the need for staff support. The environment did not provide a suitable alternative, so flasks were decided to be the best option. Staff were responsible for checking the flasks and ensuring refills.

Patients' engagement with the wider community

When appropriate, staff supported patients to access hobbies, work and education opportunities.

Despite the issues identified with contacting family when staff secluded patients, we saw other examples of staff encouraging patients to maintain relationships with their loved ones. This included making video calling available, supporting family visits and supporting patients to take Section 17 leave with family. Staff supported patients to maintain other important relationships and this was led by who the patients recorded as important to them in their care plan.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients, this included access to the service.

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

Requires improvement

Information provided to patients was in an accessible format and could be adapted to meet individual needs. This included adapting the language if a patients first language was not English. Staff provided a range of information to patients some of which included: how to complain, information about the ward and its team and treatments available.

Staff had access to interpreters and signers.

The provider had a chaplaincy service that supported the site. Staff recorded patients spiritual and/or religious preferences in care plans and supported them to access services. Staff provided patients with dietary needs or preferences with a choice of food.

Listening to and learning from concerns and complaints

In the last 12 months, the ward received two complaints and six compliments. No complaints were referred to the ombudsman.

The provider adopted a new approach to complaints and did not classify complaints as upheld, partially upheld or not upheld. Staff placed emphasis on the learning identified in all complaints to understand the motives and feelings of the person making the complaint. Staff reviewed all complaints and identified learning and any changes or quality improvement that could be made.

Staff and patients knew how to make complaints and received acknowledgement and feedback when they did.

Staff recorded informal complaints on the electronic care records and any complaints patients wished to make formal, staff recorded as an incident and a central team completed the investigation.

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

Requires improvement

Leadership

Although leaders had the knowledge, skills and experience to perform their roles, the oversight and management of the service did not meet that required to deliver positive patient care. They described their service, the challenges and the positive ways in which teams worked. Leaders explained how teams worked to provide quality care and explained actions taken to address challenges or areas that needed improvement.

Staff described visible leadership from their local managers. Staff reflected there had been an increase in visibility from senior leaders in the organisation in more recent weeks.

Staff had access to the provider's ASPIRE programme, which supported healthcare assistants to achieve nursing qualifications. The provider also offered apprenticeship opportunities in relation to management, clinical and nursing subjects. Staff had access to leadership development programmes.

Vision and strategy

The provider's vision was to Transform Lives Together. The values which underpin this vision and strategy were: Compassion: Be supportive; understand and care for our patients, their families and all in our community. Accountability: Take ownership; be proactive, be responsible, do what you say you will do. Respect: Act with integrity; be real, be open, be honest. Excellence: Innovate, learn and deliver; whatever you do, do it well.

Staff clearly described the vision and values of their organisation and how they applied them to their work with patients. Staff described that senior leaders had recently increased the message about the provider's values, and this had been a recent focus.

Staff did not always feel that they had an opportunity to contribute to discussions about their service, particularly when things changed. Staff described 'being told' about change without rationale and without consultation on what changes may be beneficial. Staff gave examples of changes being made that were not practical for their service or staff. Staff felt if they had more opportunities to engage before change, it would support the implementation of the change.

Culture

Staff felt valued by their local leaders. Most reported feeling positive about their team, work and their service.

Staff described recent challenges with change and reflected that there had been lots of recent changes, some

of which they felt could have been communicated more effectively. Staff knew how they could raise concerns and described recent appointments of Speak Up Guardians. They knew how they could raise concerns through the whistle-blowing process and described how they could raise concerns directly to the chief executive officer. Most staff felt concerns were taken seriously and said this had improved over recent months, although there were some historical examples of feeling fearful raising issues.

Managers faced some challenge from staff about changing the working pattern of shifts. Senior leaders were making this change to better support patients with continuity of care, but some staff were resistant to this.

Managers supported staff to perform their roles well and took appropriate action when staff fell below the required standards.

Staff described the team working well together, despite challenges with staffing and working with acutely unwell patients. Staff felt their ward was 'stable' and included experienced staff who knew their roles well.

Staff had access to support for their physical and emotional wellbeing. All staff described the positive support available from the trauma nurse service.

Senior leaders recognised staff success through awards that they based on the values of the provider.

Staff appraisals included conversations about career development and how the provider could support this. The service provided opportunities for support staff to train as registered mental health nurses.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. The provider appointed their first female chief executive officer, internally promoted the first female chief finance officer, appointed their first black, Asian minority ethnic executive medical director and first female chief nurse. The provider set up an Inclusion Steering Committee and employee support groups for black, Asian minority ethnic; lesbian, gay, bi-sexual and transgender plus; disability and a support group for women. Each group has an executive as their sponsor. Almost 20% of staff are black, Asian, minority ethnic and 30% of senior managers are black, Asian, minority ethnic. The provider reported a median gender pay gap of zero. The provider ran several key patient and staff events including their first Trans-inclusion Healthcare conference, St Andrews Pride, Mental Health Awareness Week, Black History Month and International Women's Day. The provider was an NHS Diversity and Inclusion Partner and facilitated workshops for 150 inclusion allies and partnered with an external agency to run trans-awareness workshops for over 100 staff.

Governance

Managers did not have appropriate oversight of issues in the service, including where care and treatment did not meet the standards for quality care.

There were issues with staff not reporting incidents and the accuracy of progress notes. We were concerned that this could impact the quality and accuracy of investigations that followed. Staff did not follow best practise and policy relating to the allocation of enhanced observations. Staffing levels did not always meet the required numbers to support patients.

Although the average data for supervision met the providers target at the time of the inspection, in January 2020 44% of registered staff and 32% of healthcare assistants received clinical supervision. Managers explained this was due to patient acuity, increased levels of enhances observation, increased use of agency staff and annual leave and sickness. Most staff did not have access to supervision during a challenging time for the service.

Managers did not ensure that staff dispensing medication had easy access to information to ensure they dispensed under the correct legal framework.

Management of risk, issues and performance

Ward managers told us they could add items to the service or organisational risk register.

The provider's risk register for the psychiatric intensive care wards identified the following red rated risks for the service; patient and staff safety, self harm incidents, patient ligature risk, recruitment and retention, patient physical health, restrictive practise and low occupancy.

Staff concerns matched those on the risk register.

The service had business continuity plans to manage emergency situations, for example, adverse weather events and influenza pandemics.

Information management

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

Requires improvement

The provider used systems to collect data from wards that were not over burdensome on staff.

Staff had access to the equipment and technology they needed to do their work.

The provider introduced a ‘patient safety dashboard’. Managers used this to review incidents and use of restrictive interventions.

The provider used key performance indicators to support managers to gauge the performance of their teams, including compliance with training, supervision and reduction in restrictive interventions.

Engagement

Staff had access to up-to-date information about the work of the provider through the intranet, emails and newsletters.

Patients and carers had opportunities to feedback about the service through questionnaires and meetings. The provider employed a dedicated involvement lead to oversee this work.

Staff had opportunities to meet the providers senior leadership team through ‘drop in’ sessions.

Senior leaders engaged with external stakeholders, for example NHS England and clinical commissioning groups.

Learning, continuous improvement and innovation

Managers offered staff the opportunity to give feedback on services and input into service development.

The provider implemented a new quality improvement approach. Quality improvement leads were visiting wards and speaking to staff about innovations and how to embed these and learn from them. The focus was on getting staff to own their ideas.

Since 1 February 2019 staff on Bayley ward had been using body worn cameras. Bayley staff took part in the trial period which was reviewed at three months by the provider. The provider involved patients throughout the trial and implementation and body worn cameras remain a standard agenda item for community meetings. Managers and staff used images from body cameras to support investigations into incidents and allegations.

Forensic inpatient or secure wards

Inadequate

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

Are forensic inpatient or secure wards safe?

Inadequate

Safe and clean environment

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff could not observe patients in all parts of the wards, however staff were aware of blind spots and mitigated these through observations. The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Managers displayed a ligature heat map on each ward which identified high risk areas.

Patients did not have nurse call alarms in their bedrooms. Staff carried personal alarms to summon help when required.

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed the provider's infection control policy, including handwashing.

Staff did not always follow safety procedures in relation to food hygiene. We found opened, unlabelled food items in fridges on Stowe and Seacole wards.

We inspected two of the three seclusion rooms at the service. Seacole ward seclusion room was occupied by a patient from another ward on the day of the inspection. Sunley ward seclusion room allowed clear observation. Stowe ward seclusion room en-suite had a blind spot. Staff reported this in October 2019 and were still waiting for maintenance to resolve this. Both seclusion rooms allowed two-way communication. They had a toilet and a clock.

The service had two extra care suites, one on Sunley ward and one on Stowe ward. We were unable to fully inspect these as they were occupied during the inspection. We were able to briefly view part of the extra care areas and they were compliant with the standards required in the Mental Health Act Code of Practice.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, the agency nurse in charge on Seacole ward told us that the emergency bag was in the office when it was located on Stowe ward, next door to Seacole ward. We observed a sign on the clinic room door advising staff that the emergency bag was located on Stowe ward.

Staff checked, maintained, and cleaned equipment.

Safe staffing

Managers had not ensured established staffing levels on all shifts.

We visited all three wards on the evening of Monday 02 March 2020. Sunley ward had been short of four staff all day. Fifteen staff were expected for the night shift, by 19:45 only 13 had arrived for work. Stowe ward had been short of two staff in the morning and three in the afternoon. Seacole ward had sufficient staff and staff told us that staffing levels had improved recently.

During our visit to Stowe ward on 04 March 2020, the ward was very short staffed, with eight staff in the morning and seven in the afternoon. There should have been 14 staff on

duty. Six staff were required to provide enhanced observations to patients. The nurse in charge reported to the manager that it was difficult to allocate staff to observations and staff would have to miss their breaks. Staff reported that Sunley ward and Seacole wards had been authorised to book more staff than needed, but Stowe ward had not. The provider advised that this was due to a combination of low vacancy rates, assessment of patient risk and required observation levels on Stowe ward. Whilst we were in the office, we observed patients in the day area with no staff around to respond to their needs; patients were knocking on the office door and asking for staff, but there were no staff present.

The provider reported 13 service failure incidents due to staff shortages between 01 September 2019 and 29 February 2020. Sunley ward reported the highest with eight, Seacole ward reported four and Stowe ward one.

The provider reported vacancy rates of 21% for registered nurses for the forensic core service between 01 March 2019 and 29 February 2020. Sunley ward reported the highest at 34%, Seacole ward reported 22% and Stowe ward reported the lowest at 6%. This was lower than the 50% reported at the last comprehensive inspection.

The provider reported vacancy rates of 11% for unregistered nurses for the forensic core service between 01 March 2019 and 29 February 2020. Sunley ward reported the highest at 25%, Stowe and Seacole wards reported the lowest at 3%. This was higher than the 9% reported at the last comprehensive inspection.

Between 01 March 2019 and 29 February 2020 workchoice staff filled 23% of shifts with Seacole ward reporting the highest use at 14% and Stowe and Sunley wards reporting 5%. Workchoice is an internal bank of staff managed by the provider.

In the same period, agency staff filled 1% of shifts, with Seacole ward reporting the highest use at 4%, Sunley ward 0.1% and Stowe ward reporting no agency use.

The main reasons for workchoice and agency usage for the wards were to provide enhanced support to patients, cover staff vacancies and sickness.

The provider reported that 15% of shifts were unfilled between 01 February 2019 and 31 January 2020. This was highest on Sunley ward with a reported 25% of shifts unfilled, Seacole ward reported 12% unfilled shifts and Stowe ward 10%. The provider advised that data for shifts were based on optimum (ideal) numbers.

Ward managers could adjust staffing levels daily to take account of case mix. Sunley ward manager told us he had authorised to increase his staffing establishment by two posts to meet patient need. When agency and workchoice nursing staff were used, they received an induction and were familiar with the ward. Managers had started to block book agency staff to cover vacant posts to ensure continuity of care.

The provider reported a turnover rate of 20% for the forensic core service between 01 February 2019 and 31 January 2020. Seacole ward reported the highest at 25%, Sunley ward reported 23% and Stowe ward 13%.

Managers supported staff who needed time off for ill health.

The sickness rate for this core service was 8% between 01 February 2019 and 31 January 2020. Sunley ward reported the highest at 10%, Seacole and Stowe wards reported 6%. This was higher than the 3% reported at the last comprehensive inspection.

Patients on Sunley ward told us that staffing levels did not always allow patients to have regular one-to-one time with their named nurse.

Patients and staff told us that staff shortages often resulted in staff cancelling escorted leave, hospital appointments and activities. We observed that a planned therapy session was cancelled on Stowe ward on the day of our visit. We also observed staff going without their breaks in order to facilitate patient leave.

Staff received and were up-to-date with appropriate mandatory training. Overall, staff in this service had undertaken 94% of the various elements of training that the provider set as mandatory. The provider reported 94% for basic life support, 80% for intermediate life support, 100% for level two safeguarding adults and children and 93% for management of actual and potential aggression training. There were no mandatory courses with a compliance rate below 75%.

The mandatory training programme was comprehensive and met the needs of staff.

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

Assessing and managing risk to patients and staff

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed these regularly. However, risk management plans for one patient on Sunley ward did not provide clear guidance for staff to manage high risk self harm behaviours.

Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. We found issues on all three wards.

We found examples of staff not completing observation records on all wards. We reviewed seven days of enhanced observation records for Sunley ward and found pages missing, staff not always signing, risk factors not always recorded and one missing observation entry. On Stowe ward, we reviewed four enhanced observation records and found 12 gaps out of 72. We observed that staff left observation paperwork in the office, came back in the office at 10:13 and completed entries for 08:00 and 09:00. Staff should complete observation records as soon as possible to ensure records are contemporaneous. On Seacole ward we reviewed 40 enhanced observation records and found 83 gaps out of 960.

We found that shift leads allocated staff to complete enhanced observations for up to 12 hours.

On Sunley ward we reviewed 10 daily shift planners and shift leads had allocated staff to enhanced observations for longer than two hours on 64 occasions. On one occasion a staff member was allocated to continuous enhanced observations (moving from patient to patient) for the entire 12 hour shift. Other staff were allocated to enhanced observations for up to six hours at a time.

On Seacole ward we reviewed nine daily shift planners and shift leads had allocated staff to enhanced observations for longer than two hours on 71 occasions. On four occasions staff had been allocated to enhanced observations for nine hours of their shift. Staff were on continuous observations for up to seven hours without a break.

On Stowe ward we reviewed six daily shift planners and found 13 occasions when shift leads had allocated staff to enhanced observations for longer than two hours. The longest time was 4.25 hours. This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain patient safety.

On Sunley ward we found two examples of the same staff being allocated to different patient observations for the same time slot. We found four examples of patients not being allocated any staff for their observations, in one example, the patient had no staff allocated for nine hours.

On Stowe ward we found one example of the same staff being allocated to different patient observations for the same time slot. We found that two patients prescribed 2:1 observations were only observed by one member of staff for an hour and a third patient prescribed 2:1 observations were only observed by one staff for four hours.

On Seacole ward one staff was allocated to enhanced observations for two patients at the same time.

Staff did not always keep patients safe from harm whilst on enhanced observations. There had been 399 incidents of patients self-harming whilst on enhanced observation between 01 September 2019 and 29 February 2020. Seacole reported the highest with 153, Sunley ward 152 and Stowe 94.

Seacole and Stowe wards reported head banging as the most frequent form of self harm and Sunley ward reported wound tampering as the most frequent.

On Seacole ward we were made aware of an incident whereby a staff member had fallen asleep when on enhanced observations of a patient and the patient tied a ligature. We were told that the staff member was suspended pending investigation.

We reviewed five incidents of patient's self harming whilst being observed by staff on Seacole ward that occurred after the Care Quality Commission took urgent enforcement action in relation to this issue.

On Sunley ward we reviewed records for a patient assessed as high risk of self harm and prescribed 2:1 enhanced observations to manage this risk. There were four incidents in February 2020 when the patient managed to self harm.

Shift leads were allocating staff to key safety roles and patient observations at the same time.

Inadequate

Forensic inpatient or secure wards

On Stowe ward shift leads had allocated staff to key safety roles and patient enhanced observations on all six daily shift planners reviewed.

We reviewed nine daily shift planners on Seacole ward. Shift leads had allocated staff to key safety roles and patient enhanced observations on two of the daily shift planners and no roles had been allocated on three out of nine daily shift planners.

We reviewed 10 daily shift planners on Sunley ward. Shift leads had allocated staff to key safety roles and patient enhanced observations on six daily shift planners. Examples included a member of staff allocated to enhanced observations and lunch duties at the same time and response staff allocated to patient enhanced observations for six hours.

We observed Sunley ward handover on 02 March 2020 and staff stated, "whoever is on safety will be doing 5 minute observations".

Staff followed the provider's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Staff applied blanket restrictions on Sunley ward. These included no access to bedrooms during the day. Hot drinks and snacks were only allowed at set times. Patients were not allowed to put their hood up. The manager advised they had to temporarily restrict snacks as patients' were 'misusing' and handing wrappers to other vulnerable patients to self harm.

Patients alleged that staff on Sunley ward used inappropriate restraint techniques. Five patients told us that three staff used inappropriate restraint techniques whereby they bent the patient's wrist and arm behind their back. We reviewed electronic records for one patient who had raised concerns and found reference in the progress notes to the patient being bruised following an incident of restraint. We raised this with the provider during the inspection and they advised they had suspended the three staff immediately and launched an investigation.

Levels of restraint significantly increased since the last comprehensive inspection. The provider reported 1,198 incidents of restraint across the forensic core service between 01 September 2019 and 29 February 2020. Sunley ward reported the highest at 718, Seacole ward reported 266 and Stowe ward 214. There were 661 incidents of restraint reported over six months at the last comprehensive inspection.

The provider reported 326 prone restraints for the same period. Sunley ward reported the highest at 219, Stowe ward reported 56 and Seacole ward 51.

Staff followed National Institute of Clinical Excellence guidance when using rapid tranquilisation. The provider reported 579 uses of rapid tranquillisation for the same period. Sunley ward reported the highest at 329, Seacole ward reported 148 and Stowe ward 102.

The wards in this service participated in the provider's restrictive interventions reduction programme. Staff told us that they would use de-escalation methods before resorting to restrictive interventions. Staff told us about appropriate different de-escalation methods they would try, for example, weighted blankets and use of ice cubes to distract from self harm urges to avoid using restrictive interventions.

There had been 253 episodes of seclusion between 01 September 2019 and 29 February 2020, the highest on Sunley ward with 253, Stowe ward reported 70 and Seacole ward 37. This was an increase since the last inspection when the provider reported 216 seclusion episodes over six months.

We reviewed 27 seclusion records (13 for Sunley ward, eight for Stowe ward and six for Seacole ward).

Staff did not always follow the Mental Health Act Code of Practice. Doctors had not completed a medical review within the first hour of seclusion in three records (two for Seacole ward and one for Stowe ward). Nurses had not completed required reviews in six records (three for Seacole ward and three for Stowe ward). Doctors had not completed continuing medical reviews in four records (two for Seacole ward, one for Stowe ward and one for Sunley ward). Multidisciplinary reviews had not taken place as required in two records for Seacole ward. We found missing details in records, for example, who authorised seclusion, what the patient had taken into the seclusion room in five records (three for Seacole ward and two for Stowe ward). Staff had not contacted families, carers or advocacy in four records (three for Seacole ward and one for Stowe ward). Staff had not completed seclusion care plans in four records (two for Seacole ward and two for Sunley ward).

Inadequate

Forensic inpatient or secure wards

We reviewed nine episodes of long-term segregation (four for Sunley ward, three for Stowe ward and one for Seacole ward). Staff did not always follow the Mental Health Act Code of Practice. There was no evidence for any of the episodes of long-term segregation that carers or family had been involved in the decision to use long-term segregation.

We found that the environment used for long-term segregation did not always meet the requirements of the Mental Health Act Code of Practice. Staff segregated three patients in their bedrooms and another in an extra care area that did not have outside access.

Staff recorded the reasons for use of long-term segregation as risk of violence to other patients, but care plans were often focused on management of self harming behaviours.

Staff did not complete all hourly observations, with missing observations from every patients' record. Observations were lacking in detail, often one-word entries.

Doctors did not complete all required medical reviews, particularly at weekends. There were missing medical reviews in all the episodes of long-term segregation. Doctors often completed reviews over the telephone at weekends in relation to long-term segregation. This was in line with the provider's policy.

Multidisciplinary team meetings did not take place as required in six of the records. None of the multidisciplinary team reviews involved an independent mental health advocate, as per the Mental Health Act Code of Practice.

A senior professional reviewed the use of long-term segregation in three out of the four records.

We reviewed external reviews for three patients. However, it was not clearly recorded that the consultant was from an external provider.

Staff did not always state in care plans the conditions to be met to discontinue the use of long-term segregation. For one patient we needed to ask a staff member to confirm that the patient was still in long-term segregation, as there was no mention of long-term segregation in the progress notes and there were no hourly observation records for 29 of the 33 days between 01 February 2020 and 04 March 2020.

One patient had an open episode of long-term segregation that started on 18 September 2018 and another that started on 30 December 2019. Staff started the second episode after the patient came out of a long period of seclusion, which they appeared to have entered from the first long-term segregation. We could not find a record of a daily medical review on seven days between 01 January 2020 and 05 March 2020.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. All staff completed level one safeguarding children and adults training and 83% of staff completed level three safeguarding children and adults training.

We were concerned that staff were not reporting all safeguarding concerns to the local authority safeguarding team. The provider reported 318 safeguarding incidents between 01 February 2019 and 31 January 2020. Sunley ward reported the highest at 167. Of the total 318 safeguarding incidents, staff reported 103 to the local authority safeguarding team. We observed an incident of self harm on our visit to Seacole ward on 24 February 2020, a senior staff member advised the incident occurred due to staff neglect. This incident was not reported to the local authority safeguarding team.

Social workers, allocated to individual wards, were responsible for overseeing safeguarding alerts during normal office hours. Outside of these hours staff would contact the local authority duty worker.

Staff followed safe procedures for children visiting the ward. There were visiting areas located outside of the wards which staff used to facilitate families visiting with children.

Staff access to essential information

Staff used an electronic record system for patient records, with some records also available in paper format, for example, Positive Behaviour Support plans.

Information needed to deliver patient care was not available to all relevant staff. We spoke with agency staff who advised they did not have access to the electronic records system.

Medicines management

Staff followed systems and processes when safely prescribing, administering and recording medicines.

Inadequate

Forensic inpatient or secure wards

However, on Seacole ward we found inhalers, suppositories and enema kits stored in an unsuitable cupboard. We raised this with a senior manager, who moved these items to suitable storage facilities.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure staff did not control patients' behaviour by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute of Clinical Excellence guidance.

However, on Seacole ward we found four trays of out of date blood bottles and two boxes of out of date blood collection tubes. We raised this with a senior manager, who addressed this immediately.

Track record on safety

Senior managers told us the Women's location reported the highest number of serious incidents across the provider. The provider reported 16 serious incidents for the forensic service from the 01 March 2019 to 29 February 2020. Seacole ward reported the highest with nine, Sunley ward reported six and Stowe ward one. The most common incident type was self harm with 11.

Reporting incidents and learning from when things go wrong

We were concerned that staff were not reporting all incidents. We observed an incident of self harm during our visit to Seacole ward on 24 February 2020. Staff had not reported this as an incident when we checked records on 03 March 2020.

We reviewed 30 incident reports for Sunley ward. Three self harm incidents had not been reported when they had happened. We observed an incident when on the ward, where staff restrained a patient in the day area. Staff had not recorded this as an incident when we checked records the following day.

We reviewed an incident for Seacole ward, which a manager approved, despite being of poor quality. The incident lacked detail, staff had not updated with required actions and the language used put the blame on the patient.

Staff received feedback from investigations of incidents via 'red top alerts' sent by email. These were also printed out and displayed in nursing offices, folders and staff were also requested to use 'read and sign' sheets for them.

Staff gave examples of changes made following incidents including the provider changing intermittent observation forms following a serious incident in Essex, changes to the debrief form and changes to the process for recording food/fluid intake following a physical health incident with a diabetic patient.

Staff spoken with said they were debriefed and received support after a serious incident.

Staff described their responsibilities relating to Duty of Candour.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Staff completed physical health assessments on admission.

Staff developed 'Positive Behaviour Support' plans with patients on all wards. These were personalised, holistic and recovery-orientated.

Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

Inadequate

Forensic inpatient or secure wards

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and delivered in line with, guidance from the National Institute of Health and Care Excellence. Interventions included dialectical behavioural therapy programme, 'reinforce appropriate implode disruptive' approach, work on psycho-social skills and trauma work.

Staff did not always provide physical health interventions in a timely manner. On Sunley ward we reviewed an incident when staff had not been able to check blood glucose levels of a diabetic patient due to incidents occurring on the ward. When staff eventually checked the patient their blood glucose level was dangerously high.

We reviewed an incident on Seacole ward when a patient's insulin administration was delayed by 2.5 hours despite the patient reminding staff. External visitors from the clinical commissioning group had to intervene to ensure the insulin was administered.

However, we observed associate practitioners visiting the wards to support patients' physical healthcare needs.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. There were several patients with 'disordered eating', some of which required nasogastric feeds at times. Nasogastric feeds consist of delivering liquid nutrients through a tube passing through the nose and into the stomach. There were staff trained to provide nasogastric feeds. Staff on Sunley ward had completed a detailed plan to support a patient requiring nasogastric feeds.

Staff supported patients to live healthier lives through healthy eating advice, smoking cessation support and support to access physical activities.

Staff used recognised rating scales to assess and record severity and outcomes. These included Health of the Nation Outcome Scales, the Short Term Assessment of Risk and Treatability, Recovering Quality of Life, Simple Physical Activity Questionnaire and the Clinical Global Impressions scale.

Staff participated in clinical audits, including audits of high dose antipsychotics.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, teams included or could access occupational therapists, physiotherapists, clinical psychologists, social workers, pharmacists and dieticians.

Staff had the experience, qualifications, skills and knowledge to meet the needs of the patient group.

Managers provided new staff with an appropriate induction. This included the corporate induction, followed by a specific Women's service induction then two weeks of shadowing on the ward.

Managers did not always support staff through regular, constructive appraisals of their work. Between 01 August 2019 and 31 January 2020, the average rate across all wards in this service was 54% for non medical staff. Sunley ward reported the lowest at 10%, Stowe ward reported 57% and Seacole ward 96%. The provider reported 100% compliance for medical staff appraisals.

Managers did not always support staff through regular, constructive clinical supervision of their work. The provider's target of clinical supervision for staff was 85% of the sessions required. Between 01 August 2019 and 31 January 2020, the average rate across all wards in this service was 73% for staff. Seacole ward reported the lowest at 54%, Sunley ward reported 74% and Stowe ward 92%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. This included training in use of emergency response belts and soft cuffs, search training, boundary training, role of peer support workers, personality disorder awareness, reinforce appropriate, implode disruptive approach, trauma informed care, relational security and dialectical behaviour therapy skills coaching. However, staff were supporting a number of transgender patients during our visit and only one member of staff on Sunley ward had completed transgender awareness training.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers gave examples of supporting staff to improve their performance, for example, in relation to the correct completion of seclusion paperwork.

Inadequate

Forensic inpatient or secure wards

Multidisciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed two ward rounds and one discharge care programme approach meeting. They were all well attended and discussed all aspects of the patients' care and treatment.

Staff did not always share clear information about patients and any changes in their care. Staff did not always complete handovers in line with the provider's policy and procedures. We found examples of poor record keeping of handovers. Staff arrived late to handovers, we observed handovers on all wards and staff arrived late to each one.

Support staff were leading handovers when there were no regular registered nursing staff on duty. However, on Sunley ward we observed a handover to a member of staff transferred from another ward. The handover was thorough and respectful, and staff used photos of patients to support the process. Staff described risk issues and how to manage them in detail.

The service had recently introduced daily multidisciplinary handovers, called 'safety huddles' in response to concerns that staff were not following patients' care plans in relation to managing risk. We observed 'safety huddles' on each ward. Whilst they were detailed and informative only one was attended by one support staff.

Ward teams had effective working relationships within the service and with external agencies, including local authorities and commissioners.

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

However, staff did not always follow the Mental Health Act Code of Practice in relation to seclusion, long-term segregation and the application of blanket restrictions.

As of 29 February 2020, 90% of the workforce in this service received training in the Mental Health Act.

The training compliance reported during this inspection was higher than the 76% reported at the last inspection.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Patients had easy access to information about independent mental health advocacy and advocates visited the wards weekly and attended community meetings.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff and patients reported that section 17 leave (permission to leave the hospital) was not always taken due to staff shortages.

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

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

The service did not accommodate informal patients.

Good practice in applying the Mental Capacity Act

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles.

As of 29 February 2020, 90% of the workforce in this service received training in the Mental Capacity Act.

The training compliance reported during this inspection was higher than the 76% reported at the last inspection.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Inadequate

Forensic inpatient or secure wards

Are forensic inpatient or secure wards caring?

Inadequate

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with kindness, dignity and respect.

On Sunley ward we observed staff in the office discussing a patient reporting that staff told them "if you are going to self harm, do it properly", two patients also told Care Quality Commission inspectors that staff had said this to them.

Other Sunley ward patients described incidents of staff making derogatory remarks. Examples included; staff telling a patient to "sort themselves out" when engaging in self harm behaviour; staff telling colleagues to "let them do it" when a patient was self harming; staff not intervening when patients were self harming; staff throwing a towel at a patient self harming and telling them "when you have done, clean it up"; another patient described staff telling them to clear up their mess after self harming.

Staff on Sunley ward reported that colleagues used inappropriate language to describe patients, such as; "self harmers", "kicking off" and "attention seeking". We spoke with another staff member who used the phrase "self harmer". Following the inspection the provider evidenced that appropriate action had been taken in regards to one member of staff.

We observed a handover in Sunley ward's office and the member of staff handing over described a patient as a "self harmer". Another staff member told us they had previously worked with "demented" patients.

On Sunley ward we observed a staff member responding to a patient who approached them say "I'm not on shift yet".

We reviewed records of a Sunley ward patient who identified as male. Their notes clearly stated that they wished to be referred to using male pronouns, however we viewed a referral letter to the local acute hospital that referred to the patient as 'she'. The provider advised that it was non ward based staff that made the referral and there was no intent to misgender the patient.

On Seacole ward we reviewed notes for one patient and staff recorded "if patient is not showered and dressed by the time the day shift commences then she is to stay in pyjamas for the whole day and she must go without a shower".

Staff supported most patients to understand and manage their own care, treatment or condition.

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

Patients on Stowe ward were positive about staff on the ward and told us that staff treated them well and behaved kindly.

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

Staff followed policy to keep patient information confidential.

Involvement in care

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

Staff involved most patients and gave them access to their care planning and risk assessments. However, four patients told us they were not involved in decisions about their treatment and care.

Staff involved patients in decisions about the service, when appropriate. The provider introduced a new recruitment process, which involved patients interviewing candidates.

Patients could give feedback on the service and their treatment and staff supported them to do this. We observed two ward rounds and one discharge care programme approach meeting and staff involved patients. Patients chaired weekly community meetings on all wards.

Staff made sure patients could access advocacy services.

We requested contact details for carers for all women's wards, however none were provided for the forensic service.

There was a carers centre located on site and one patient told us that the service supported their parent to visit by

provision of accommodation and travel expenses. We observed a discharge care programme approach meeting on Stowe ward, which was attended by the patient's husband.

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

Good

Access and discharge

The service was commissioned to provide a national facility, with patients from all parts of the United Kingdom and Ireland.

There was always a bed available when patients returned from leave.

Staff did not move patients between wards during an admission episode unless clinically justified and in the interests of the patient.

The provider reported 12 patient transfers over the last six months. Five were patients moving from Seacole ward to the other two forensic wards due to Seacole ward closing. Five more were patient transfers between the forensic wards. The remaining two were patient transfers to low secure wards.

When staff moved or discharged patients, this happened at an appropriate time of day.

Staff completed discharge plans for patients.

The provider reported four delayed discharges, two on Stowe ward, and one each on Seacole and Sunley wards. The delays were due to a lack of suitable placements being available.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms, which they personalised.

Patients had somewhere secure to store their possessions.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. This included quiet rooms, craft rooms, therapy kitchens, sensory rooms, distress tolerance room and a low stimulation room. Patients had access to outside courtyards, unsupervised access was individually risk assessed. Patients on Stowe and Seacole wards could access a suite of activity rooms upstairs. Rooms included a gym, library, IT suite, healthcare suite, art room and music room. We observed Stowe ward patients engaging in a coffee morning activity in this area.

Each ward had a quiet room and meeting rooms located outside the main ward areas that staff used to facilitate patients' family visits.

Each ward had a phone room where patients could make phone calls.

On Sunley ward patients were only allowed hot drinks at set times throughout the day. Patients on certain 'risk levels' were only allowed snacks at set times.

Stowe and Seacole wards had drink stations for patients to access hot drinks and water coolers for water and did not impose set snack times.

Patients' engagement with the wider community

A patient on Seacole ward set up dog sponsorship for the ward and led on fund raising activities for a dog rescue charity.

Patients on Seacole ward had created a memorial flower bed in the garden to provide an area where patients could remember loved ones who had died.

Staff supported patients to maintain contact with families through visits and video conferencing.

Meeting the needs of all people who use the service

The service made adjustments for patients with a disability – for example, by ensuring disabled people's access to premises. The provider equipped wards with assisted bathrooms.

Managers ensured that staff and patients had easy access to interpreters and/or signers.

Staff offered patients a choice of food to meet religious and cultural dietary requirements. This included vegetarian, vegan, halal and kosher meals.

Inadequate

Forensic inpatient or secure wards

Staff ensured that patients had access to appropriate spiritual support. The service had access to chaplaincy support, which included access to leaders from different religions including Christianity, Islam and Wicca.

Staff were supporting a number of transgender patients during our visit. However, only one member of staff on Sunley ward had completed transgender awareness training and we found one example of staff misgendering a patient.

Listening to and learning from concerns and complaints

The provider reported the forensic service received 21 complaints in the 12 months prior to the inspection. The provider had not provided information on whether the complaints were upheld or not. The provider told us their emphasis is on learning from complaints and what change and quality improvement have been made as a result of the feedback received through concerns and complaints. All complaints are reviewed and reported on with the focus that there is always an opportunity to learn and review procedures such as through understanding the motives and feelings of the person who raised the complaint. The provider had one complaint for Seacole ward referred to the ombudsman. Seacole ward received the most complaints, with eight. The most common theme of complaints was staff attitude and behaviour.

Patients spoken with told us they knew how to complain. However, we reviewed records of a patient who told us they had complained about staff neglect and attitude. We found three references to the patient wishing to complain but no further information or follow up actions. We escalated this to senior staff and requested an update, this was not provided.

Staff spoken with knew how to handle complaints appropriately.

Managers provided feedback about complaints in team meetings.

The provider reported the forensic service received eight compliments in the 12 months prior to the inspection. Stowe ward received the highest with four.

Are forensic inpatient or secure wards well-led?

Leadership

Leaders did not always understand the issues, priorities and challenges the service faced. We were not assured that leaders had taken sufficient action to address concerns raised during the focused inspection in January and February 2020. Seacole ward continued to report incidents of patients self harming whilst on enhanced observations. Staff were not following the provider's handover procedure, which resulted in key risk information not being shared. Concerns identified on Seacole ward were also occurring on Sunley ward.

Leaders were reactive rather than proactive in their response to issues, this was demonstrated by the delay in responding to concerns raised. However, leaders had recently decided to close Seacole ward and staff we spoke with told us this was a relief.

Senior leaders had increased their visibility in the service recently and were approachable for patients and staff. Staff spoken with told us that the new operational lead and clinical leads for the service were visible on the wards. Staff told us that the chief executive officer visited regularly.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

The provider's vision was to Transform Lives Together. The values which underpin this vision and strategy were: Compassion: Be supportive; understand and care for our patients, their families and all in our community. Accountability: Take ownership; be proactive, be responsible, do what you say you will do. Respect: Act with integrity; be real, be open, be honest. Excellence: Innovate, learn and deliver; whatever you do, do it well.

Although the provider's senior leadership team successfully communicated the provider's vision and values to the frontline staff in this service, staff did not always embed them in practice. Senior managers told us there was a focus on role modelling the values and managing staff that did not demonstrate them in their work.

Staff told us that the service model created pressure to admit patients, which resulted in patient acuity being too

high. Senior managers told us that they were encouraged to keep within their own specialist practice unit. The impact of this was that it was a smaller pool of resources to draw from which made it difficult to cover staff shifts and therapy staff absences. The model also created unhealthy competition, with the provider internally publishing performance tables for the different units.

Culture

Staff reported that managers supported them well, they were aware of the speak up guardians and were confident to raise concerns. However, nurses did not feel they had a strong voice and were not aware of the new nursing strategy. Staff reported that nursing leaders were not visible.

Some staff (mostly registered nurses and support staff) didn't feel valued. Other staff reported that they felt more valued and respected under the current chief executive officer.

Managers dealt with poor staff performance when needed.

Stowe ward team worked well together, and their manager dealt with any difficulties appropriately. Sunley ward manager was new to the role and was starting to implement positive changes. The provider introduced new leaders to Seacole ward who were supporting staff with the planned closure.

Senior leaders expressed concerns about how well teams worked together due to the shift system in place that separated staff into two teams that never worked together. This impacted on patient care as teams were not working cohesively and consistently. The provider was implementing a plan to remove this shift system from across all locations.

Staff appraisals included conversations about career development and how the provider could support this. The service provided opportunities for support staff to train as registered mental health nurses.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. The provider appointed their first female chief executive officer, internally promoted the first female chief finance officer, appointed their first black, Asian minority ethnic executive medical director and first female chief nurse. The provider set up an Inclusion Steering Committee and employee support groups for black, Asian minority ethnic; lesbian, gay, bi-sexual and transgender plus; disability and a support group for women. Each group has an executive as their sponsor. Almost 20% of staff are black, Asian, minority ethnic and 30% of senior managers are black, Asian, minority ethnic. The provider reported a median gender pay gap of zero. The provider ran several key patient and staff events including their first Trans-inclusion Healthcare conference, St Andrews Pride, Mental Health Awareness Week, Black History Month and International Women's Day. The provider was an NHS Diversity and Inclusion Partner and facilitated workshops for 150 inclusion allies and partnered with an external agency to run trans-awareness workshops for over 100 staff. However, we found concerns in this core service relating to how staff cared for transgender patients.

The provider reported a sickness rate of 8% for the forensic core service between 01 February 2019 and 31 January 2020. Sunley ward reported the highest at 10%.

Occupational health services and a trauma nurse supported staff physical and emotional health needs. The provider invested in a programme of support to promote staff well-being. This included training staff in mental health first aid (to support colleagues), staff wellbeing events, massages and Zumba classes.

The provider recognised staff success within the service through staff awards. The provider issued awards based on their values on a monthly and quarterly basis, which then culminated in an organisation wide annual awards ceremony for the overall winners.

Governance

The leadership and governance did not always support the delivery of high quality, person-centred care. The providers governance processes had not addressed staff failures to follow the provider's procedures on enhanced observations and handovers. There was no evidence that the provider undertook regular and effective audits of these issues.

We were not assured that the provider acted to ensure staff followed the enhanced observations procedure when supporting patients assessed as high risk of self harm. The provider reported 399 actual incidents of patients' self harm whilst on enhanced observations between 01 September 2019 and 29 February 2020.

Inadequate

Forensic inpatient or secure wards

Leaders had not ensured staff were reporting all incidents or that all safeguarding incidents were reported to the local authority safeguarding team.

Governance systems were not effective in ensuring shifts were covered by sufficient numbers of staff of the right grade and experience. The provider reported that 15% of shifts were unfilled between 01 February 2019 and 31 January 2020.

There was a clear framework of what must be discussed at a ward and service level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. However, this had not always translated into action to implement required changes.

Management of risk, issues and performance

Ward managers told us they could add items to the service or organisational risk register.

The provider's risk register identified the following red rated risks for the service; patient and staff safety, clinical variation, patient self harm, identifying new requirements, equipment quality, declining occupancy levels, commissioning and discharge planning, management information and insight, patient physical healthcare needs, family/patient relations and patient involvement.

Staff concerns matched those on the risk register.

The service had business continuity plans to manage emergency situations, for example, adverse weather events and influenza pandemics.

Information management

The provider used systems to collect data from wards that were not over burdensome on staff.

Staff had access to the equipment and technology they needed to do their work.

The provider introduced a 'patient safety dashboard'. Managers used this to review incidents and use of restrictive interventions.

The provider used key performance indicators to support managers to gauge the performance of their teams, including compliance with training, supervision and reduction in restrictive interventions. However, managers did not always take action in response to these.

Staff did not always make referrals to the local authority safeguarding team and notifications to the Care Quality Commission as required.

Engagement

Staff had access to up-to-date information about the work of the provider through the intranet, emails and newsletters.

Patients and carers had opportunities to feedback about the service through questionnaires and meetings. The provider employed a dedicated involvement lead to oversee this work.

Staff had opportunities to meet the providers senior leadership team through 'drop in' sessions.

Senior leaders engaged with external stakeholders, for example NHS England and clinical commissioning groups.

Learning, continuous improvement and innovation

Managers offered staff the opportunity to give feedback on services and input into service development.

The provider implemented a new quality improvement approach. Quality improvement leads were visiting wards and speaking to staff about innovations and how to embed these and learn from them. The focus was on getting staff to own their ideas. Quality improvement initiatives included the introduction of the 'safewards' approach on Sunley ward and Stowe ward. This approach aims to reduce conflict and containment on mental health wards.

Stowe ward was part of national pilot for blended low/ medium secure wards for women. The aim of the blended ward model was to reduce the number of transitions and length of time in secure settings for women. Staff were supporting patients to be discharged directly back into the community. The model was underpinned by a trauma informed care approach and co-produced with patients. As part of the model, peer support workers had been recruited to the ward.

Stowe ward were also participating in research led by a PHD student who was studying physical health and activities of patients.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

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

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

Inadequate

Safe and clean environment

Managers had not ensured safe and clean environments on all wards. Spring Hill and Elgar wards cleanliness was poor, whereas, Sinclair, Thornton, Spencer South and Hereward Wake wards were generally clean. Hereward Wake's craft and computer room had a damp, sewage type smell and the ward manager told us there had been historical leaks in these parts of the building. The provider did not confirm they had taken any action to address this.

Staff completed annual risk assessments of the care environment on all wards. However, on Elgar ward, the ward risk assessment did not include the garden courtyard which patients had access to, and staff had not completed the action plan to mitigate risks.

Staff could observe patients in most parts of the wards. The wards were set in older style buildings that did not always allow for good lines of sight. Managers mitigated the risk of blind spots which hindered staff observing patients, with curved mirrors. On Elgar ward there was a blind spot in the lounge where patients were difficult to observe. Managers ensured staff were based in communal areas to observe patients and viewing panels were available in internal bedroom doors to enable staff to view patients whilst in their bedrooms.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Managers had removed many of the significant ligature risks and curtain and shower rails were fully collapsible throughout the wards. Patient bedrooms contained toilet, shower and bathroom fittings that were anti-ligature and fittings such as taps on handwashing sinks in communal areas were anti-ligature. Managers mitigated the risks of ligatures on the wards through staffing levels and patient observations.

We saw ligature cutters placed throughout all wards secured in locked boxes that staff had access to. Ligature cutters are a hooked knife or tool specifically designed for use to release a ligature safely.

The wards complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Not all ward areas were clean, well maintained, well-furnished and fit for purpose. Spring Hill and Elgar wards standards of cleanliness were poor. Staff had not maintained up to date cleaning records on Elgar, Spring Hill, Sinclair and Hereward Wake wards; staff did not clean all ward areas regularly.

On Spring Hill, we saw a cleaning audit from 02 December 2019 with a 74% compliance rate, and an incomplete action plan dated 03/12/2020. We asked the ward manager for cleaning records and saw one record for one day in the inspection week and were told other cleaning records were kept by the cleaner and were not available.

On Elgar ward cleanliness was poor. Staff completed a cleaning audit on the 11 December 2019 with an 82%

compliance rate. There was no evidence of an action plan. Managers told us the ward received a deep clean in February 2020 and agreed staff had not maintained cleaning standards.

In the Elgar ward extra care suite, we saw what looked like blood on the floor, and were told by staff the suite was last used by a patient two weeks ago. We escalated this issue with the modern matron, who acted immediately to address this.

On Sinclair ward the manager told us the cleaner held cleaning records, but there were none. On Sinclair ward a cleaning audit dated 23 February 2020 showed 85% compliance, but there were no actions noted on the action plan. On Sinclair ward, Spring Hill ward and Elgar wards cleaning audits over time commented on “high dust” “built up dust” “dusty cupboards” and “dusty air vents.”

Three patients on Hereward Wake told us staff did not keep the ward clean and sanitary dispensers and waste bins were not regularly emptied. One of the patients told us the top of her wardrobe was thick with dust, and remnants of dust were often left in her bedroom sink. These issues were fed back to the manager.

Staff generally followed the provider’s infection control policy, including for hand washing except for Spring Hill ward where we saw staff administrating medicines from the nurse’s station where there was no access to a sink to wash hands to maintain infection control.

All wards had seclusion rooms except Hereward Wake and Thornton ward. Elgar seclusion room was being repaired, and currently out of use. The seclusion room is where a patient can be taken if they need to be kept away from others for a short time if the patient presents with significant behavioural disturbance. When a patient was placed in seclusion, staff kept records and followed best practice guidelines.

The seclusion room allowed clear observation and two-way communication. The viewing panel in the seclusion room door permitted staff to carry out observations. Patients had a working intercom system so they could speak with staff while in seclusion. There was a separate toilet and shower room which could be accessed by patients without having to come out of seclusion. The taps in the sink and shower of the seclusion suites were anti-ligature.

There was a clock outside the seclusion room so patients that were secluded could remain oriented to time. Seclusion rooms had heating and ventilation which staff controlled from a panel outside the room. Patients using the seclusion room had a tear-proof seclusion mattress, which afforded comfort especially during longer periods of seclusion.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Ward refrigerators were properly monitored by ward and pharmacy staff to ensure that medicines were stored at the correct temperature and were safe to use.

Emergency bags were available which included resuscitation equipment and emergency drugs. Staff checked these daily to ensure that all equipment was in date and fit for purpose. Staff checked, maintained and cleaned clinic equipment.

Safe staffing

The service did not have enough staff with the right skills, qualifications and experience for each shift. Staff and patients told us there was not the right staff mix, for example female staff at night on Spring Hill ward to meet patient’s needs. On Spring Hill and Sinclair wards we found examples of staff observing patients for long hours without taking proper breaks. We observed recurrent feedback from patients in community meetings about the length of time it took to answer the doors to let patients back in to the ward from section 17 leave in area D in Spring Hill. 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 needed to help other wards, staffing levels were reduced because extra staff were not always found.

Managers deployed high use of workchoice and agency staff. Managers requested and where possible used staff familiar with the service. Agency and workchoice staff were largely used for patient observations. Managers made sure all workchoice and agency staff had an induction and understood the service before starting their shift. Workchoice staff were provided with an induction and annual refresher training to be effective in their role.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Regular nursing agency staff were block booked. Agency staff had a safety briefing at the start of the shift that included detailed information about patients, their risks and needs and the ward environment.

Managers told us new staff were due to join the women's service as another service was closing on the same site; and staff would be redeployed to the women's service. There were also further interviews planned and new staff due to start for both nurses and health care assistants.

Managers calculated the number and grade of nurses and healthcare assistants for each shift and used a shift system referred to as 'A and B' which covered three long days from 7.30am- 7.45pm pm, with a one-hour break. Managers told us the shift system will cease from June 2020 to allow for more flexible working.

The provider supplied staffing data following our inspection. From November 2019 to February 2020. The total percentage of staffing showed, that 77.5% of shifts were filled by permanent staff and 22.5% were a combination of agency, workchoice staff and unfilled shifts. However, staff rotas, ward and community meeting minutes, and patients and staff feedback indicated there was large reliance on workchoice and agency staff. The provider advised that data for shifts were based on optimum (ideal) numbers.

The provider supplied registered nurse vacancy percentages for the last 12 months from March 2019 to February 2020. Hereward Wake ward had the average highest vacancy rate at 24% and Thornton ward followed at 23.5%. The lowest vacancy rate was Spring Hill at 9%. Both Elgar and Spencer South wards showed over recruitment on average of 6.5%. The average nurse vacancies for each ward for the last 12 months were as follows: Elgar -5.5%, Sinclair 17.0%, Spencer South -7.5%, Spring Hill 9.0%, Thornton 23.5% and Hereward Wake were at 24.0%. Managers identified difficulties in recruiting and retaining quality nurses.

The provider supplied vacancy rate percentages for health care assistants for the last 12 months March 2019 to February 2020. Spencer South ward had the average highest vacancy rate at 34% and Elgar ward followed at 28.5%. The lowest vacancy rate was Hereward Wake at 9%. Both Thornton and Spring Hill wards at 12.5%. Sinclair managers had over recruited with an average vacancy rate of -6.5%.

The provider supplied sickness percentages for the last 12 months March 2019 to February 2020. The average for each ward were as follows: Elgar ward 8.5%, Sinclair ward 7%, Spring Hill 5%, Thornton 4.5%, Spencer South 4% and Hereward Wake at 4%.

The provider supplied staff turnover percentages for the last 12 months March 2019 to February 2020. Spring Hill had the average highest turnover rate at 16% and the lowest turnover rate was Spencer South at 6.5%. In March 2019 Elgar ward was 11% and increased in February 2020 to 20%. Spring Hill was in March 2019 at 23% and decreased to 13% in February 2020. The average for each ward for the last 12 months were as follows: Spring Hill 16%, Thornton 15.5%, Sinclair ward 13%, Hereward Wake 13%, Elgar ward 11.5% and Spencer South 6.5%.

Managers supported staff who needed time off for ill health and helped to keep sickness rates low.

Patients had regular one to one session with their named nurse. However, patients on Spring Hill and Elgar ward told us that they did not have regular time with their named nurse. We saw some staff were rushed, and other staff did not engage with the patients. On Spring Hill, we saw on the activity timetable that four out of five of the activities allocated to nursing staff on the morning of 02 March 2020 did not take place except for the sensory group. In interviews with Spring Hill patients and staff they told us access to the courtyard for fresh air, depended on sufficient staffing levels.

Across wards patients told us section 17 leave was frequently cancelled due to staff shortages. Patients told us they felt upset and disappointed as they had worked hard to get their leave. This was most evident on Sinclair, Elgar, Spring Hill wards. We saw some 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.

There was not the right staff mix to meet patients' needs. Patients and staff told us on Spring Hill ward there were too many male staff at night and not enough females. In the areas B, C and D there were not enough female staff to support patients. We were unable to verify this with staffing data. These issues were recorded in patients' community

meeting notes. The provider advised that the manager was addressing this issue and regular agency staff were being block booked to cover this. However, we did not see evidence to support this during or after the inspection.

Managers failed to provide enough staff to safely observe patients on some wards. Most patients on the wards required frequent observations. There were a significant number of additional workchoice and agency healthcare assistants to provide observations due to risks around patients' mental and physical health.

Staff shared key information to keep patients safe when handing over their care to others. However, staff on Spring Hill could not easily find information the Care Quality Commission inspection team requested. We asked for the physical health folder, environmental checks and the health and safety folder; staff struggled to find these.

The service had enough day and night time medical cover and a doctor was available to go to the ward quickly in an emergency. There was a rota for out of hours cover. For example, seclusion records showed doctors attending quickly. Managers could call locums when they needed additional medical cover.

Staff received and were up-to-date with appropriate mandatory training. Overall, staff in this service had undertaken 96% of the various elements of training that the provider set as mandatory. The lowest to highest compliance rate were as follows: Spring Hill 90%, Sinclair 95%, Elgar 96%, Hereward Wake 97%, Spencer South 97%, Thornton ward 98%. The provider reported 89% for basic life support, 92% for intermediate life support, 99% for level two safeguarding adults and children and 93% for management of actual and potential aggression training. There were no mandatory courses with a compliance rate below 75%.

Managers monitored mandatory training and alerted staff when they needed to update their training. The ward dashboards identified training uptake figures and ward managers acted where training was due or overdue for renewal.

Assessing and managing risk to patients and staff

We examined 27 care records. Staff completed a risk assessment for each patient when they were admitted and reviewed risk assessments regularly. Patients had up-to-date risk assessments which identified the risks patients posed to themselves or others with risk management plans in place. The only exception was on Elgar ward where six patients' risk assessments sampled lacked detail with repeated information amongst all records indicating that the same information had been copied and pasted in to all risk assessment records.

Managers were not managing patients risks effectively. Spring Hill ward divided patients in areas identified as 'A, B, C D' that were locked to prevent movement between areas. Patients remained in areas depending on their level of risk. Spring Hill ward's areas were divided according to the level of risk patients presented with; area A was termed 'extra care' and had a de-escalation and a seclusion room. In area B, which was on the ground floor, patients were cared for who had a high level of risk. This area was small and confined, with bedrooms, bathrooms and the court yard all locked off by staff. Areas C and D were upstairs, and patients had the freedom to move around, with a mini kitchen off the lounge and a staff member designated in the communal area for observation and support. We saw and heard the ward was disorganised, staff looked rushed and patients complained about the many restrictions and not feeling safe. The provider advised that they had not received any formal complaints of this nature from patients.

On Spring Hill ward, we found three examples of staff continuously undertaking five minutes and 15 minutes observations for longer than two hours, for a total duration of between three to seven hours. Staff were at risk of fatigue. On Sinclair ward we found four occasions where staff over two days, completed four hours of continuous patient observations without a break. A staff member from Sinclair ward told us over a 12 hour shift they would cover around four patients observing at arm's length for two hours, or two and half hours with one patient with one-hour break during the day. They felt this was unsafe and often felt exhausted, and had raised this with the ward manager, but no action was taken. Another staff member from Sinclair ward worked a 10.5-hour day and observed the same patient continuously for 4.5 hours without a break.

Staff on Spring Hill ward told us the last six to eight weeks had been challenging with several patients being admitted with high risks of assaulting patients and staff, head banging and choking.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Staff completed positive behavioural support plans to support patients in avoiding and managing challenging behaviour. Most positive behavioural support plans were individualised and detailed.

Staff used the providers risk assessment tool which referred to as 'support levels' where risk levels are from one to six. Patients at level one required more support and a higher observation level and patients at level five and six required less restrictions and less frequent observations. Staff reviewed patients' level of risk daily at each staff handover.

Staff knew about any risks to most patients and usually acted to prevent or reduce risks. Where patients had physical health problems that could present with risks that needed to be managed these were documented. For example, we saw where patients were on high dose anti-psychotics were supported with physical health observations regularly to check for side effects.

However, on Elgar ward we found a serious incident where staff had not identified or responded to changing risks effectively. Incident records showed, on 6 November 2019 at 00.37 that the ward alarm was raised by staff as they believed patient A was in an advanced state of stroke. However, care records recorded the incident as starting earlier at 00:25 mins. Switchboard staff did not process the incident as a medical emergency so there was a delay in the ambulance being called at 00:54 hrs. A serious incident draft report said there was an 80-minute delay between the first alert and the eventual transfer to acute hospital. The patient had not suffered a stroke and was discharged back to Elgar ward the following day. The provider was in the process of investigating this serious incident.

Staff followed the provider's policies and procedures when they needed to search patients or patients' bedrooms to keep them safe from harm. Staff carried out random and specific searches on patients on the wards and worked within the provider's policy on searching patients.

Staff on Spring Hill and Elgar wards subjected patients to blanket restrictions which included access to bedrooms, toilets, the outdoor courtyard which was locked all day, the amounts of toilet paper, vaping which was allocated times and accessing snacks and hot and cold drinks. Staff on Spring Hill ward restricted patients to set times throughout the day to access snacks and drinks. This was confirmed by community meeting notes. However, the provider advised that all restrictions were recorded in the least restrictive practice logs and individual risk assessments for patients were reviewed twice a week by the multi disciplinary team.

On Spring Hill ward areas, A and B, patients and staff told us about the following blanket restrictions which applied to all patients irrespective of individual patient risk assessments. This included; access to courtyard limited and sometimes has to be cut short due to staff not being available; patients' sleeping in lounge at 08.45-09.00 as they had been locked out of their bedrooms; one patient's bedroom corridor being locked at night (presented a possible fire risk) opening the lounge at 07.15; patients in area B being forced to exit their bedrooms at 07.30 to 09.30; bedrooms locked, toilets, quiet room and courtyard doors all locked; no access to drinks unless requested, toilet tissue- no access to, and have to ask staff for this. The exception was in area C where a patient on level 3 support could access their bedroom for one hour during the day. There were other blanket restrictions on patients irrespective of individual patient's risk needs.

On Elgar ward blanket restrictions were set, in between meals, snack times were only available at 3pm and 8.30pm. Vaping was only allowed four times a day.

We saw many patients choose vaping as smoking cessation support. Staff had different restrictions in place with patients given set times to vape outside which ranged from between four times to seven times a day. However, many patients told us they were not able to take the set vape slots as they were not enough staff available to allow access to the courtyard. We were concerned that this practice did not support patients with their physical health and encourage them to live healthier lives.

Staff participated in the provider's restrictive interventions reduction programme. Staff had received training on reducing restrictive practice. Despite the other blanket restrictions, restrictions on patients' belongings were kept to a minimum. For example, patients across the wards were allowed their own mobile phones. The only exception where patients did not have a mobile phone was where this had been risk assessed for individual patients on clinical or security grounds.

Managers pulled information from the electronic incident record system to monitor and analyse the use of restrictive interventions such as restraint and seclusion. Managers

discussed reducing restrictive practice at monthly governance meetings by monitoring levels of physical restraint and where necessary developing action plans to address any issues.

Staff made every attempt to avoid using restraint by using de-escalation techniques and only restrained patients when these failed and when necessary to keep the patient or others safe. Staff understood the Mental Capacity Act definition of restraint and, where appropriate, worked within it.

The data showed restrictive interventions on Spring Hill ward were high between September 2019 and February 2020 including incidents of restraint, prone restraint, rapid tranquilisation and seclusion. We saw and heard the ward was disorganised, staff looked rushed and patients complained about the many restrictions and not feeling safe. Patients cared for within the ward presented with challenging behaviours and a high level of risk

In September 2019 on Spring Hill ward there were 32 restraint incidents involving four patients, with incidents increasing monthly. In February 2020 there were 181 incidents involving seven patients.

Prone restraint is a restraint in which a person is in a face-down position against the floor or another surface. On Spring Hill ward in October 2019 there were six prone restraints involving three patients, in February 2020 incidents increased to 17 with four patients.

Rapid tranquilisation is the use of medication usually intramuscular (or exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed. The administration of rapid tranquilisation on Spring Hill ward was 34 incidences in November 2019, 84 in January 2020 and 86 in February 2020. St Andrew's did not provide a breakdown of individual patient's numbers that received rapid tranquilisation.

The numbers of patients secluded on Spring Hill ward increased monthly from September 2019 to February 2020. Three in September 2019, eight in October 2019, 18 in November and December 2019, 25 in January 2020 and 21 in February 2020. The other five wards seclusions for the same period ranged from nil to the highest at nine patients for Sinclair ward in November 2019.

We looked at seclusion monitoring records over the period of 1 December 2019 to 29 February 2020. We looked at four seclusion monitoring records for Sinclair ward. Three records were generally compliant and followed the Mental Health Act 1983 Code of Practice. We looked at nine seclusion monitoring records for Spring Hill ward. Eight records were generally compliant and followed the Mental Health Act 1983 Code of Practice. A theme noted across both Sinclair and Spring Hill were staff not contacting family members and advocates as part of seclusion process and monitoring. We looked at one seclusion monitoring record for Elgar ward. These records were generally compliant and followed the Mental Health Act 1983 Code of Practice.

We reviewed on Spring Hill ward two long term segregation records; one open episode and one closed episode. The closed episode of long-term segregation lasted 31 days. The open episode had been open for 43 days when we reviewed the record on 5 March 2020. For one episode of long-term segregation, staff wrote the care plan two days after the episode started. As long-term segregation is not a reactive management strategy staff should have completed this before the patient went into long-term segregation. Staff informed the patient's family of the long-term segregation on both occasions, but there was no evidence of their involvement in the decision. There was no involvement from an independent mental health advocate in the decisions.

Staff used two sets of records to document patient observations, entries were missing, medical reviews did not take place and reviews did not involve Independent Mental Health Advocates. The open episode of long-term segregation had one hourly observation form completed, for the first day of the long-term segregation. All other hourly recording was done using the Enhanced Support recording forms under the Enhanced Support tab in the patient's record. Entries did not evidence that a daily medical review was taking place. There were missing entries for 29, 23, 22 and 20 February, and other dates. On the closed episode of long-term segregation staff had created an hourly observation form on 10 August 2019 at 06:00. This form contained records of the hourly observations for 10 August 2019 for 00:00 to 08:00. The recorded observations before 06:00 pre-date the creation of the form. The form was last updated 28 August 2019. A second hourly observation form created 10 August 2019 at 22:49 contained observation records for 10 August 00:00 to

08:00 and 20:00 to 24:00. All but the last two observations predate the creation of the form. Where there were two sets of observation entries between 00:00 and 08:00, the entries were different and the names of staff against the entries were different. There were missing daily medical reviews on five occasions. None of the multi-disciplinary team reviews involved an independent mental health advocate, as per the Code of Practice. We could not see any record of a weekly multidisciplinary team review.

There was a monthly review on the 27 February 2020 by an independent team from Thornton ward, consisting of a consultant psychiatrist, nurse manager, occupational therapist and the clinical nurse lead from Sinclair ward.

The rationale for using long-term segregation rather than another approach was not always clear. The reason often appeared to be related to the management of self-harming behaviours.

Although the decision to use long-term segregation was generally made by between four and six people, there was only evidence of parental involvement on one occasion. There was no evidence of involvement by an independent mental health advocate.

For two patients there were occasions when it was not clear in the patients records whether the patients were subject to long-term segregation, with conflicting reports in the progress notes for one patient. Staff were therefore, not clear on the management plan for caring for these patients.

No record had a full set of hourly observations, even though patients were on one-to-one or higher observation. There were inconsistencies in where the hourly observations were recorded, with evidence that some were not contemporaneous. Forms were pre-filled with staff who were due to work with the patient. Observations were generally one word or short phrases, often repeated throughout the shift.

Daily medical reviews were variable in their frequency and the quality of the review. On some records there were a small number of missed reviews, on others they were regularly missed. We were told that the on-call doctor had been given extra time at the weekend to do face-to-face reviews, but we found the they were often still done by telephone.

Some patients had thorough weekly multi-disciplinary team reviews, others had none. The quality of some multidisciplinary team reviews was poor.

Independent reviews for seclusion usually took place when required. Managers ensured external reviews were completed for all patients that required them.

The conditions under which patients should be reintroduced to the general ward following seclusion were usually unclear. These should be part of the care plan that is put together before the patient is segregated.

During a senior doctor interview, we were told there was a three-monthly challenge meeting to confirm that long-term segregation was still required. Barriers to ending long-term segregation were discussed at this. We saw no evidence of this happening in the records.

The service was getting better at being proactive in identifying potential seclusion and long-term segregation episodes.

If a patient moves into seclusion from long-term segregation and is there for more than two weeks, staff restart the long-term segregation, including the three-month review timetable. If it is shorter than two weeks staff, consider the long-term segregation to have continued. The rationale for this decision is that the Mental Health Act Code of Practice does not give any guidance, and the patient's situation might have changed during this period of seclusion.

The policy relating to long-term segregation is included the restrictive practice policy and states there will be an independent review of long-term segregation every six weeks. A clinician based at the provider, but from a different team should complete this. A team external to the provider should complete external three-monthly reviews. The provider kept track of external reviews centrally.

On Spencer South ward staff told us three patients with disordered eating were frequently restrained during feeding times. We briefly observed an episode of care and saw staff assist a patient with feeding with sensitivity. We saw one set of records to confirm restraint was recorded and monitored. However, the recording of restraint detailed that "Management of actual or potential aggression holds" were used but did not identify which part of the body was

restrained. Management of actual or potential aggression is an accredited training programme that teaches staff management and intervention techniques to cope with escalating behaviour in a professional and safe manner.

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquilisation. The guidelines are evidence-based recommendations for health and care in England. On occasions, patients may be prescribed medicines known as rapid tranquillisation to help with extreme episodes of agitation, anxiety and sometimes violence. Following rapid tranquillisation, nursing staff were required to record regular observations of the patient's blood pressure, temperature, oxygen saturation and respiratory rate. The corresponding care records for patients who had been given rapid tranquillisation showed clearly that staff recorded the reasons for giving rapid tranquilisation and had recorded observations. Where patients declined these checks, staff completed checks based on visual observation.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role. Training in safeguarding adults and safeguarding children was mandatory and required staff to attend initial and regular refresher training. Five wards were 100% compliant with safeguarding children and young adults' level 1- 2. Spring Hill ward had 96% compliance. For safeguarding level 3 classroom training four wards were 100% compliant, with Elgar ward 86% and Spring Hill 91% compliance.

Staff kept up-to-date with their safeguarding training. Most wards had a social worker the designated safeguarding lead who provided advise to staff on their responsibilities.

Staff could give clear examples of how to protect patients from harassment and discrimination. Staff we spoke with had a good understanding of safeguarding procedures and what to do when faced with a safeguarding concern.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The provider had notified us of safeguarding incidents. In each of the safeguarding cases, it was clear that the provider had taken appropriate action to safeguard vulnerable patients. When the staff in the service were in doubt, they informed us they would speak to local authority staff for guidance on whether a referral was necessary.

Where safeguarding incidents included verbal or physical abuse between patients, managers accepted that they would benefit from clear, written criteria around thresholds for referrals agreed with the local authority. Staff knew how to use the whistleblowing process, we saw written information in wards with contact numbers.

Staff followed clear procedures to keep children visiting the ward safe. There was a range of family visiting rooms on and off wards, so children could safely visit patients. The provider's social workers assessed the appropriateness of children visiting patients. They liaised with relevant authorities and made the arrangements for child visiting where this was deemed to be in the best interests of the child.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider had social workers who had established improved working relations with the local authority safeguarding team and checked that appropriate and timely action was taken to protect vulnerable adults. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

We reviewed recent safeguarding incident investigations. We saw that there was evidence to show that within investigations staff acted promptly to raise safeguarding incidents and speak out. Each incident was considered and investigated by a senior member of clinical staff. Where safeguarding incidents concerned allegations against staff, we saw that managers acted and now looked further than personnel factors when looking at the incident including considering wider root cause analysis, organisational and systemic factors as part of their local investigations. The ward social worker reviewed safeguarding incidents, kept a

safeguarding record to monitor incidents and proactively liaised with the local authority, where appropriate. Managers discussed safeguarding incidents at team meetings.

Staff access to essential information

Patient notes varied from basic to comprehensive notes; and most staff could access them easily. St Andrew's had an electronic care notes system. Patient records were completed electronically by staff or scanned in. We had difficulties on some wards accessing patients' records as the electronic systems went off line. Staff said this happened from time to time.

Records were stored securely on password protected computers and applications.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We saw evidence of effective e-prescribing (electronic prescription) on wards. There were some exceptions of ineffective medicine management on Spring Hill and Elgar ward.

On Spring Hill ward, we observed medication being administered from the nurse's office on three occasions over two days. The medication trolley was left in the nurse's office for two days during the Care Quality Commission inspection. There was no access to a sink to wash hands and maintain infection control. On the 02 March 2020 we checked the room temperature in the nurse's office and recorded it at 26.8C. There was no monitoring of room temperatures to ensure medication was stored at the correct temperature and was safe to use.

We found on Elgar ward staff had not labelled one patient's inhaler with the patient's name and a second inhalers name label was missing. We saw over stocking of medicines in the clinic room, for example 15 boxes of sodium valproate and 23 boxes of travel sickness medication.

Staff generally stored and managed medicines and prescribing documents in line with the provider's policy. Staff ensured medicines including controlled drugs were securely stored and emergency medicines were regularly checked to ensure they were available if needed. Fridge temperatures were monitored to make sure that medicines were stored at correct temperatures.

We saw that following audits from the pharmacist, staff had acted to address any areas identified to ensure safe prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We reviewed medicines charts and patient records in detail and found staff general held effective records of the treatment patients received.

Staff followed current national practice to check patients had the correct medicines. We reviewed consent to treatment documentation and found medicines were prescribed in accordance with the provisions of the Mental Health Act. We also found that the legal certificates authorising treatment for mental disorder for detained patients were kept with the medicine chart as required by the Mental Health Act Code of Practice. This meant that staff administering medicines could check that they had the appropriate paperwork and legal authority to give medication to detained patients at the time the medicine was given. The exception was on Sinclair ward where action was not taken following an audit on consent to treatment records for five patients.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw safety alerts in clinic rooms and medical alerts were routinely discussed as a standard agenda item in governance meetings and disseminated to staff as required. Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance.

The systems in place for managing medicines minimised risks to keep patients safe. Some patients were prescribed medicine that required regular monitoring of blood levels to ensure that ongoing treatment for their mental disorder was safe, such as lithium or clozapine treatments. We saw monitoring had been completed at the appropriate intervals. There was an effective recording system to provide assurances to managers and prescribing clinicians that these essential blood results were requested or followed up in a timely manner.

Track record on safety

All independent providers were required to submit notifications of significant incidents to us, relevant events including safeguarding incidents. Senior managers told us

the Women's location reported the highest number of serious incidents across the provider. For serious incidences between June 2019 and February 2020 Elgar had seven, Spring Hill four, Sinclair four, Spencer South two and Hereward Wake one.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. St Andrew's had a standard system of incident monitoring. Staff we spoke with understood the types of incidents to report. We looked at the incidents that had occurred between March 2019 and February 2020 for this core service. The highest incidences were Spring Hill ward with 1123 followed by Elgar ward 620. Spring Hill ward and Elgar ward identified with most risks and concerns. The lowest incidences were at Hereward Wake ward at 375.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff completed reports for incidents and near misses on the provider's computerised incident reporting system. Senior managers reviewed incidents entries each day and decisions were made regarding any further action which may be required. This could include referral to safeguarding, further investigation or reporting as a serious incident.

We found details in handover notes of a medication error that occurred on Sinclair ward where staff prescribed medicine in an emergency as the patient's mental state had significantly declined. Patient A had been non-compliant with medication which they were prescribed to take three times daily for up to four weeks. Patient A from the 6th January to 3rd February 2020 declined 52 doses of prescribed medication. Care records showed there had been a decline in the patient's mental state as there had been numerous incidents of seclusion and self-harm risk (potential suicide risk from ligature). It was unclear why the medication error had not been picked up earlier. Clonazepam was administered under emergency Mental Health Act Section 62. This is where urgent treatment can be administered to save life, prevent injury to the patient or others, prevent serious deterioration of psychiatric condition or to alleviate serious suffering. The incident was reported on the risk management record keeping system, discussed with the relevant professionals, information given to the patient and family, and lessons learnt.

Staff understood duty of candour. They were open, transparent and gave patients a full explanation when things went wrong. Managers and staff were aware of their responsibilities in relation to duty of candour which required staff to be open and offer an apology when an incident occurred resulting in serious patient harm.

Managers debriefed and supported staff after any serious incident. Clinical psychologists offered debrief sessions immediately following serious incidents. Staff could be referred for trauma counselling. Managers and staff on some wards attended daily safety huddles where incidents were reviewed, and actions planned.

Managers investigated incidents. Managers had access to a range of performance indicators through a computerised dashboard which provided information for incidents on each ward including numbers, types and categories of incidents, the timeliness of recording incidents, analysis of the days and times when most incidents occurred, the types of injuries sustained and interventions used, where appropriate. Managers therefore had very detailed safety incident data for each ward. This could be accessed centrally by managers and at senior level. Managers met regularly to ensure there were appropriate reviews of the dashboards and incidents at the service.

Most staff received feedback from investigation of incidents, both internal and external to the service. Managers discussed learning from incidents at ward team meetings and governance meetings. However, staff on Sinclair and Elgar ward told us they did not have regular staff meetings due to acuity of patients and shortages of staff. Not all staff met regularly to discuss the feedback and look at improvements to patient care.

The provider had not always made changes as a result of feedback. At the last inspection in 2017 we identified the same issues. These included the high use of temporary staff, insufficient staffing, staff being confused about what constituted seclusion and long-term segregation, and staff placing restrictions on patients at Spring Hill ward.

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

(for example, treatment is effective)

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Requires improvement

Assessment of needs and planning of care

Staff generally completed assessments of patients, including full assessment of their and mental health needs in a timely manner at, or soon after admission. We examined 27 patient care records. Most records contained a full assessment of needs with input from the multi-disciplinary team. An exception was on Sinclair ward three out of five care plans physical health assessment were not evident. On Spencer South one patients care plans did not fully reflect the patient's physical mobility needs to use a wheel chair to mobilise.

Staff developed individual care plans and updated them when needed. However, staff on Hereward Wake ward did not provide sufficient detail in the nutritional care plan for one patient around nasogastric feeding (NG). Nasogastric feeding is where a narrow feeding tube is placed through your nose down into your stomach. The tube can be used to give fluids, medications and liquid food complete with nutrients directly into your stomach.

Care records included positive behaviour support plans and "all about me" records. On Sinclair ward one patient's care plan did not include their therapy goals around communication. In Spring Hill ward staff nursed two patients in 'area A' or 'extra care' due to their risk to themselves and others with staff continuously observing them. The patients' positive behaviour support plans stated how to care for these patients in crisis such as in in long term segregation.

Care plans varied in quality from basic to detailed care plans, but were generally personalised, holistic and recovery orientated. We saw from care records that patients had access to podiatry, dentist, and speech and language therapy.

Best practice in treatment and care

Managers did not always respond to the physical health needs of patients. Managers and staff told us the provider's physical health team was available during week days and they called the out of hours staff consisting of a nurse and doctor who were available until 9:00pm. However, we found examples of patients not receiving good access to physical healthcare, including access to specialists when needed. On Sinclair ward care records showed patient B approached a nurse on 22 February 2020 as they had a urine infection which they were prescribed medication for. Patient B refused to take the medicine and had to wait up to four days to be prescribed an alternative antibiotic. The patient raised a formal complaint. A patient on Elgar ward waited 80 minutes to access an ambulance to hospital in a medical emergency.

Staff monitored and recorded patient food and fluid intake where appropriate.

Staff used health of the nation outcome scores to assess and record severity and outcomes of patient's mental health and progress or deterioration. Staff also used national early warning score which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

Staff provided a range of care and treatment interventions suitable for the patient group. We saw a structured daily programme of dialectical behaviour therapy. The main goals of dialectical behaviour therapy are to teach patients how to live in the moment, cope healthily with stress, regulate emotions, and improve relationships with others. Therapists offered a comprehensive therapy programme including: one to one therapy to meet personal goals, homework group, skills group, and a graduate group for patients progressing. Staff recorded patient's progress through the dialectical behaviour therapy program. We observed patients supporting and encouraging each other to meet these goals.

Staff provided a range of treatment and care for clients based on national guidance and best practice. We saw across wards, patients had short mindfulness sessions in the morning and afternoon with daily goal setting. We saw staff and patients on Thornton ward had purchased a hamster as part of recovery work with patients.

The provider described Spring Hill ward as a specialised personality disorder treatment pathway, therefore it did not function entirely as a rehabilitation ward. Areas 'A and B' did not provide a rehabilitation model of care to patients. Patients cared for within these areas presented with challenging behaviours and a high level of risk. Staff managed these areas with a high level of security, access to other areas of the ward and rooms within the ward were locked off, patients rarely had section 17 leave or

community leave, and patients were not necessarily at the stage in their recovery where they were ready for rehabilitation. This contrasted with areas 'C and D' within Spring Hill ward where the emphasis on rehabilitation was clear. We discussed this with the provider who advised the service was set up this way to meet commissioning requirements.

Skilled staff to deliver care

The team consisted of doctors, nurses, clinical psychologists, occupational therapists, social workers, pharmacists, dieticians, and health care assistants. Spencer South ward manager told us the ward's purpose and function were due to change to care for patients with eating disorders. A dietician and experienced doctor (with eating disorder experience) provided advice and guidance to staff. Managers had appointed a dietician to work on Spencer South and was due to commence work soon. Nurses had received nasogastric feeding tube training and managers had planned further specialist training. Three dialectical behaviour therapy integrated practice unit / wards were supported by a clinical nurse lead.

Some staff had received specialist training RAID (Reinforce Appropriate, Implode Disruptive behaviour). This training emphasised that staff provide a positive approach to working with very challenging behaviour.

Members of the multi-disciplinary team had undertaken specialist training to facilitate the daily structured dialectical behaviour program. This was the primary form of psychological therapy provided on Spring Hill, Spencer South and Hereward Wake wards. We saw and heard how staff carried dialectical behaviour principles through to patient's risk planning, risk management, recovery goals, and discharge planning. Staff on most wards told us they were offered a weekly group supervision as part of the training for dialectical behaviour therapy and ethos of the wards. Staff considered this to be reflective practice/group supervision.

Staff received a structured induction lasting from two days to five days depending on their grade and roles within the team. Staff reported the induction was good.

Managers ensured that staff had received clinical supervision and annual appraisal. On Spring Hill managers told us they were struggling to find the time to provide supervision as the ward was unsettled. However, the average rate for the last six months for clinical supervision between August 2019 to January 2020 was 79% for non-medical staff and 94% medical staff.

The average rate for the last six months between August 2019 to January 2020 for clinical supervision for non-medical staff was low for Elgar ward at 58% for non-medical staff and 69% for medical staff, Sinclair non-medical staff were 72% and medical staff were 89%, Thornton non-medical staff 86% medical staff 96%, Hereward Wake non-medical staff 93% and medical staff 100%. Spencer South showed high compliance rate with non-medical staff 99% and medical staff 100%.

Managers had completed annual appraisals with 100% of staff. As of 5 March 2020, all doctors were appropriately appraised and revalidated.

Not all staff had access to regular team meetings. Managers and staff on Sinclair told us team meetings were not happening regularly. The last team meeting was July 2019. This was because of staff shortages and the acuity of patients. The manager had produced staff newsletters for staff in December 2019 and February 2020 and a mandatory staff team day was planned in March.

On Spring Hill ward, we found only one set of team meeting minutes for 28 February 2020 which were messy and hard to follow. Team meeting minutes showed concerns from staff about a lack of staff, skill mix, too many male staff on nights and not enough female staff. One manager told us they struggled to encourage all staff to attend team meetings on their non-working days.

Managers dealt with poor staff performance and effectively.

Multi-disciplinary and inter-agency team work

The multi-disciplinary team meetings took place weekly to review patients' progress and to address any issues with patients care and treatment. On Spring Hill ward some patients had thorough weekly multi-disciplinary team reviews, others had none. We viewed meeting records and saw the quality of some multi-disciplinary team reviews was poor. However, we observed a multi-disciplinary meeting on Thornton ward. We saw exemplary participation from all staff involved. Staff demonstrated a person-centred approach, joint planning, a review of individual care plans and recovery goals, and identifying and managing risks.

Staff met at the beginning and end of shifts to handover information regarding patient care. This included information on individual patient's risks, observation levels 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. During our inspection we saw a patient's local commissioner visiting the ward. Social workers attached to wards liaised regularly with local authority social services.

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

Ninety three percent of staff had trained in the Mental Health Act. Staff were trained and had a generally good understanding of the Mental Health Act, the Code of Practice and the guiding principles. However, staff did not always follow the Mental Health Act Code of Practice in relation to seclusion, long-term segregation and the application of blanket restrictions.

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 staff applied the Mental Health Act 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.

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.

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 patient's capacity.

We reviewed consent to treatment documentation and found medicines were prescribed in accordance with the provisions of the Mental Health Act. We found that the legal certificates authorising treatment for mental disorder for detained patients were kept with the medicine chart as required by the Mental Health Act Code of Practice. This meant that staff administering medicines could check that they had the appropriate paperwork and legal authority to give medication to detained patients at the time the medicine was given. The only exception was on Sinclair ward for consent to treatment audits. On Sinclair ward a peer review audit dated 03 March 2020 for consent to treatment identified that five patient records were not completed. We checked if these issues had been actioned at 3.30pm the following day 04 March 2020 but they remained outstanding.

Patients across the site could access the Independent Mental Health Advocacy service. An independent advocate is specially trained to support people to understand their rights under the Mental Health Act and support patients with decisions about their care and treatment. Patients had access to advocacy and independent mental health advocates based on the provider's site for support with complaints and tribunals.

Good practice in applying the Mental Capacity Act

Ninety three percent of staff had received 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 a patient did lack capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture, and history. However, on Elgar ward staff had not completed capacity assessments or best interest forms for three out of six patients in relation to specific decisions.

The multi-disciplinary team discussed capacity assessments during ward rounds. Managers would

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

circulate an updated feedback form to staff weekly. We saw patient note entries where staff discussed capacity with the patient. Most 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 service.

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

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Staff treated most patients with respect and compassion. They usually respected patients' privacy and dignity and supported their individual needs. However, on Elgar ward we saw some staff sitting on window ledges twiddling keys, with poor interaction with patients. Staff on Elgar ward and Spring Hill ward did not uphold patients' privacy and dignity when administering medicines through a wooden hatch. Staff on Elgar ward did not maintain a patient's dignity in a timely way when caring for a patient who was naked in the communal area.

We saw examples of staff kindness and support. We observed staff on Hereward Wake ward caring for one patient after a "difficult" nasogastric tube feed and provided after care support with a hand massage. On Thornton ward a staff member came onto the ward on their day off to cook Christmas dinner for patients. Staff understood the individual needs of patients.

On Spencer ward we saw staff assisting patients with disordered eating nasogastric tube feeding in a room off the main communal area. We heard two patients distressed and crying out over a short period. We clearly heard this in the main communal area and was difficult to listen to and did not allow for patients' dignity and respect. Managers told us the seclusion room was rarely used and there were plans to convert this room to use with patients with disordered eating at feeding times. The seclusion room was situated away from the main area and would allow patients greater privacy and dignity.

Involvement in care

Patients were involved in their care planning unless they had declined. Care plans evidenced that staff included patient preferences and were individualised.

Staff generally involved patients in decisions about their care, treatment and changes to the service. Staff consulted patients about their experience of the service through patients' community meetings.

Managers had had not used patients' feedback to make improvements. On Spring Hill ward, we saw three sets of community meeting minutes for February and March 2020 with numerous concerns listed from patients: weekend activities not happening; staff getting hurt by levels of aggression from patients; lack of regular female staff at night to talk to; impact of staffing required on area A, means less staff on area B; drinks at 2.30pm instead of 3pm; hard to get out in to the stable block as when you press the buzzer to return from leave, no one answers for up to thirty minutes. There was no evidence that the concerns raised had been addressed.

Staff offered families and carers support and provided them with information about external support agencies where appropriate.

Staff ensured that patients could access advocacy. We saw on wards patient telephones provided free calls direct to the provider's advocacy service. However, on Sinclair and Spring Hill wards, staff had not informed advocates for three patients' periods of seclusion.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

Average bed occupancy over the last twelve months on wards for, Spencer South 66%, Thornton 77%, Sinclair 85%, Spring Hill 88%, Elgar 95%, Hereward Wake 98%. For Elgar and Hereward Wake wards occupancy higher than 90%risks overcrowding, indicating that St Andrews may have to turn away patients and postpone the provision of required healthcare.

Managers on Spring Hill ward told us there had been new admissions, over a six to eight-week period, of challenging patients. One patient had transferred from a service and was very unwell. Another patient's documented history from another provider did not match the person's presentation. Staff had been assaulted by patients with one staff member being injured with broken ribs and other staff being bitten and scratched.

The provider advised that Spring Hill ward provided a pathway from acute admissions to rehabilitation. On admission to area A, patients presented with higher levels of risk than could be managed in a "locked rehabilitation" service, while areas C and D focused on community reintegration and rehabilitation. The service accepted patients from all parts of the country. If possible, staff discharged patients to a suitable placement closer to home. Staff and managers arranged meetings with patients' local commissioners, social workers and community mental health teams.

Staff developed discharge plans for most patients, which included housing options, education and employment. 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 about discharge planning, one patient said they were getting some work experience at St Andrews.

Patients who went on section 17 leave, had access to their own bed upon return. Managers said there was a bed available in the provider's Psychiatric Intensive Care Unit (PICU) if a patient became unwell during their admission on the ward.

The provider reported delayed discharges in the last 12 months. Spencer South and Hereward Wake reported one each, Sinclair two, and Spring Hill four. This was due to no suitable community placements being available.

The facilities promote recovery, comfort, dignity and confidentiality

All wards offered a range of single bedrooms with full en-suite facilities or bedrooms with access to communal bathrooms. Some wards had bedrooms and staff areas upstairs. On each ward, there was a clinic room, a range of other rooms and enclosed courtyards. The exception was on Spring Hill ward which separated areas in to 'A, B, C D' which were sectioned off by locked doors. Different resources were available to meet patient's needs. Managers told us all the women's long stay rehabilitation wards would move in April 2020 to more appropriate premises.

Patients from most wards had access to a gym, craft room and separate kitchen if they wished to engage in activities and learn to cook some meals. There was a dedicated visitors' room on or off the wards. Most patients had their own mobile phones. Patients had access to a pay phone on the ward.

Facilities and premises used on some wards were not appropriate for the service provided. However, the provider advised that they had assessed this and were planning to address through a programme of ward moves and refurbishment. We saw Spring Hill ward was disorganised, staff looked rushed and patients complained about the many restrictions and not feeling safe. The ward was grubby, untidy and disorganised. Storage cupboards with patients' belongings were messy and items were all over the place. The nurses' office was untidy, with folders on shelves that had fallen. Patients on Spring Hill ward found it hard to access facilities and premises due to blanket restrictions and staff shortages. In areas A and B, the furnishings were basic and bare. Staff referred to these areas as "sterile areas" as there were little to no furnishings. Area B was for patients with medium risks, this area was small and confined, with bedrooms, bathroom, court yard all locked off by staff. Areas C and D were upstairs and

presented as a more homely environment in line with rehabilitation purposes. We saw patients had the freedom to move around, with a mini kitchen off the lounge and a staff member designated in the communal area for observation and support. In the stable block patients could call a buzzer to ask to leave the ward. However, patients and staff told us they were frequently left waiting up to thirty minutes to get in and out of this area.

Elgar ward was unwelcoming, bare and lacked comfortable furnishings. Staff did not appear to engage with patients. However, we saw an afternoon music session facilitated by the occupational therapist with song sheets and good participation by six patients.

Staff did not deliver services in a way that focused on patients' holistic needs. On Spring Hill and Elgar wards, patients had outside space but could only access this if staffing levels allowed which impacted patients access to fresh air and regular vape breaks.

Patients personalised their bedrooms. We saw patients had personal possessions in their room. For example, photographs, large televisions and CD players. 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 provision on Spencer South, Spring Hill and Elgar wards, including larger bedrooms and assisted toilet facilities. Staff could assist patients upstairs using a lift. The garden and other facilities could be accessed. One patient on Elgar ward who needed disabled access told us the disabled toilet was used by all patients and they could not always access this when they needed to.

Staff had information leaflets in a variety of formats, including easy read and pictorial. Secure noticeboards were in place.

Staff had access to a language interpreter if needed. Managers provided patients on Sinclair ward with support from signers who were qualified in British Sign Language (BSL) to support them with their communication needs from 7:00 till 10:00pm seven days a week. British Sign Language is a form of sign language that is used in Britain and involves the use of hand movements, gestures, body language and facial expressions to communicate. It is predominantly used by people who are either deaf or have a hearing impairment. The signers would support patients with formal meetings such as ward rounds and care programme meetings as well as at other times for activities and more general communication. Together with the deployment of signing staff, deaf patients could communicate effectively with staff about their care and treatment.

The provider supplied 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. Overall patients were satisfied with the food.

There was a chaplaincy service that provided spiritual support for patients from all faiths.

Within the service patients could use a multi-faith room, visiting room or quiet area as a place to meet their spiritual needs. There was a chaplaincy service and access to spiritual leaders for other faiths. Staff took patients to an onsite chapel and provided information about faith when requested.

Patients' engagement with the wider community

Staff ensured that patients had access to education and work opportunities. One patient worked in a charity shop one day a week and served drinks at the chapel on Sunday. Other patients told us about work experience on site at the café and library.

We saw staff supported patients to maintain contact with their families and carers. Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the service and the wider community.

Listening to and learning from concerns and complaints

St Andrews provided data around compliments and complaints in the last 12 months. There were no complaints referred to by the Ombudsman. Spring Hill ward had the highest complaints at 13 including one serious incident and confirmed the risks on this ward. Sinclair six complaints and Spencer South four, including one serious incident, Elgar three complaints including one serious incident, Hereward Wake three, and Thornton two. The provider had investigated the complaints, learnt

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

lessons and had apologised when required in line with the duty of candour. The highest numbers of compliments received ranged from Thornton ward with 12 and Spencer South with one.

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

Requires improvement

Leadership

Not all leaders had the necessary experience, knowledge, capacity and capability to lead effectively. One manager worked across two wards; Spencer South and Hereward Wake and showed effective leadership.

Most managers had a good understanding of the service they managed, but spoke about staff vacancies, difficulties with recruitment, high use of temporary staff, pressures to seek additional staff from the integrated practice units, and patient acuity impacting on staff attendance for team meetings.

Leadership development opportunities were available. However, this was at times, difficult to attend due to staffing levels.

Vision and strategy

The provider's vision was to Transform Lives Together. The values which underpin this vision and strategy were: Compassion: Be supportive; understand and care for our patients, their families and all in our community. Accountability: Take ownership; be proactive, be responsible, do what you say you will do. Respect: Act with integrity; be real, be open, be honest. Excellence: Innovate, learn and deliver; whatever you do, do it well.

Not all staff felt valued. Mostly nurses and health care assistants did not feel valued. Nurses did not feel they had a strong voice and none of them knew about the new nursing strategy. Nurse leadership was not visible and there was no time for reflective practice. Staff were positive about the executive team and that positive changes were happening with the current chief executive in place.

On Elgar ward we saw not all staff encompassed key elements of the provider's vision and values with empathy, dignity and respect for patients. Staff on the ward were not clear about the rehabilitation model they were delivering.

Culture

Staff told us they felt able to raise concerns without fear of retribution. However, some staff were worried about talking to the Care Quality Commission inspection team about working long hours without enough breaks.

Staff 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. However, staff felt there were lots of changes at once. When short staffed, managers were moving staff around, staff felt demoralised and burnt out, did not feel safe, and that health care assistants were running shifts when agency nurses were on duty. Staff were concerned there was a lack of guidance and lack of personal protective equipment for COVID-19. However, the provider confirmed following the inspection that at no point had they run out of personal protective equipment.

Staff knew how to use the whistleblowing process and about the role of the Speak Up Guardian.

Managers dealt with poor staff performance when needed.

Governance

Leaders has not ensured there were sufficient staffing, and that staff observing patients for long periods of times received sufficient breaks. Not all staff were able to access regular team meetings and understaffing levels impacted on patients access to section 17 leave and therapeutic activities.

Managers monitored staff sickness, turnover and performance. Staffing concerns were most significant on Elgar and Spring Hill wards. Data from the last 12 months sickness rates on Elgar were 8.5% and Spring Hill 5%. Staff turnover rates for Spring Hill average rate at 16%. In March

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

2019 Elgar ward staff turnover rate was 11% and increased in February 2020 to 20%. Health care assistant vacancy rates on Elgar ward were high at 28.5%. However, there was an over recruitment of nurses, the average nurse vacancies for Elgar ward were minus 5.5%. The staffing establishment numbers were being met on Elgar and Spring Hill wards at the beginning of a shift; but when there was a need for increased staffing because of observations or staff needed to help other wards, staffing levels were reduced because extra staff were not always found.

Leaders had no oversight of quality, cleanliness, upkeep and safety of Elgar and Spring Hill wards. Cleanliness was poor on both wards. Facilities and premises were not appropriate for the service being delivered. Managers told us there were plans to move staff from one service that was closing to the Women's service, with changes due in April. Staff did not always adhere to the Mental Health Act Code of Practice, with confusion as to which records should be completed caring for patients in long-term segregation, decision making, and consent. Some staff were confused about what constituted seclusion and long-term segregation.

In areas A and B in Spring Hill ward did not provide a rehabilitation model of care to enable patient's recovery and rehabilitation.

Managers failed to provide regular supervision for Elgar and Spring hill wards. Records showed for Elgar that clinical supervision for non-medical staff was 58% and medical staff 69%, for Spring Hill for non-medical staff 79% and 94% for medical staff.

Staff told us there were concerns around the provider's model of integrated practice units. There was pressure to keep within integrated practice units when looking for additional staffing. This meant "a smaller pool to draw upon" and it was difficult to find cover for colleagues, for example, allied health professionals. Staff felt there were integrated practice unit budget pressures and unhealthy competition as league tables were internally published.

Management of risk, issues and performance

Managers did not always deal with risks and issues appropriately or in a timely way. The service had systems for identifying risks and plans to eliminate or reduce them. However, on Spring Hill and Elgar wards, staff did not manage risks effectively. Services were delivered in a way that placed restrictions on patients' lives, access to bedrooms, toilets, the outdoor courtyard which was locked all day, the amounts of toilet paper, vaping which was allocated times and accessing snacks and hot and cold drinks. Staff did not deliver services in a way that focused on patients' holistic needs.

Leaders failed to act. On Spring Hill medicines were not stored at the correct temperature and were therefore not safe to use. We saw examples where staff failed to ensure patients received health care at the right time.

Information management

St Andrew's collected, analysed, managed and used information generally well to support all its activities, using secure systems with security safeguards. However, leaders had failed to act on high use of restrictive interventions on Spring hill ward, cleaning audits and one consent to treatment audit.

Staff had access to sufficient technology to carry out their roles effectively and generally up-dated patient records in a timely manner. Staff stored confidential records pertaining to the service on a password protected encrypted system.

Staff submitted data and notifications to external bodies and internal departments as required. The service had protocols for submission of notifications for example, Care Quality Commission notifiable incidents and safeguarding notifications.

Engagement

Patients and carers had opportunities to give feedback on the service they received through weekly community meetings. However, On Spring Hill and Elgar wards patient community meeting minutes showed managers and staff did not always act on patient feedback. Patients told us when staff cancelled their section 17 leave, they felt upset and disappointed as they had worked hard to get their leave. Many patients we spoke provided concerning feedback about care on Spring Hill and Elgar wards.

Staff, patients and carers had access to up to date information about the work of the St Andrew's and the services they used through leaflets and through a dedicated webpage on the internet.

Learning, continuous improvement and innovation

The provider implemented a new quality improvement approach. Quality improvement leads were visiting wards and speaking to staff about innovations and how to embed

these and learn from them. The focus was on getting staff to own their ideas. Quality improvement initiatives included speeding up completion of leave requests and providing patients with mobile devices to access their care plans.

Dialectical behaviour therapy input was effective, established and had embedded treatment recovery programmes on most wards.

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. A senior member of staff and the safety advisor completed a thorough ligature risk assessment of all ward areas and removed or reduced any risks they identified. However, although the ligature risk assessment on Sitwell ward was in date, it was not current with least restrictive changes that had been made to the ward. The ligature risk assessment stated the ward had an extra care suite which staff advised it no longer had and was being used as a quiet area. The ligature risk assessment also stated the door to the telephone is locked when not in use, but it was not locked. When we asked staff about this the ward had changed its practices to be least restrictive but had not updated this on the risk assessment.

Staff could observe patients in all parts of the wards. Blind spots were mitigated by the installation of mirrors.

The ward complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms. Staff carried these on their belt and if activated pinpointed their location. Staff called for further assistance across the site using a radio. Patients did not have call alarms in their bedrooms. However, the provider advised all patients had a care plan detailing how they would access help.

Ward areas were well maintained, well furnished and fit for purpose.

Staff did not always follow the provider's infection prevention and control policy.

Not all ward areas were clean, and staff did not learn from audits. We reviewed the last three quarterly cleanliness audits on Sitwell ward. They recorded there were red bags in the laundry room mixed with white bags on the floor. Patient clothes were kept in white laundry bags for general washing or red laundry bags for soiled items of clothing. We saw the laundry room on the first day of our inspection visit and noted 12 white laundry bags and four red laundry bags on the floor. Staff had not labelled any of these bags. We also observed multiple piles of un-bagged laundry on top of the washing machine. We spoke to the ward manager about this on the first day on our inspection and they rectified this by the next day and a patient told us they now had their own wash baskets.

Dedicated domestic staff made sure cleaning records were up-to-date and the premises were clean.

Spencer North and Sitwell wards had seclusion rooms. Spencer North seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. We were unable to check the seclusion room on Sitwell ward as it was occupied by a patient throughout our inspection visit.

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

Staff checked, maintained, and cleaned equipment.

Safe staffing

Requires improvement

Wards for people with learning disabilities or autism

The service did not have enough nursing and support staff to keep patients safe. Spencer North reported a vacancy rate of 40% for registered nurses as of 29 February 2020. For the same time period Sitwell ward reported a vacancy rate of 20% for registered nurses. Billing Lodge reported no registered nurse vacancies.

Billing Lodge reported a vacancy rate of 50% for support staff as of 29 February 2020. For the same time period Sitwell ward reported a vacancy rate of 3% for support staff. Spencer North had over-recruited for support staff by 60%.

The service used workchoice and agency nurses to cover shifts. Workchoice is an internal bank of staff managed by the provider. Between 1 February 2019 and 31 January 2020, of the 9625 total shifts available, 14% were filled by workchoice staff to cover enhanced support, sickness, absence or vacancy. The highest use was on Billing Lodge (489) as this service is a small step-down service with only one permanent staff member seconded to it, and Sitwell (293). Spencer North had the lowest use of workchoice staff (38).

In the same period, agency staff covered less than 1% of available shifts for staff. The only service who used agency was Billing Lodge.

During the same period 16% of available shifts were unable to be filled by permanent, workchoice or agency staff. The highest was on Spencer North (899), followed by Sitwell (347) and then Billing Lodge (218). Seven out of 10 patients we spoke with told us the wards were short staffed. The provider advised that data for shifts were based on optimum (ideal) numbers.

The main reasons for workchoice and agency usage for the wards were to provide enhanced support to patients, cover staff sickness, absence and vacancies.

Managers requested workchoice and agency staff familiar with the service. Managers made sure all workchoice and agency staff had a full induction and understood the service before starting their shift.

Billing Lodge reported 25% staff leavers between 1 March 2019 and 29 February 2020. Sitwell ward reported 6% staff leavers between 1 March 2019 and 29 February 2020. Spencer North ward reported 24% staff leavers between 1 March 2019 and 29 February 2020.

Managers supported staff who needed time off for ill health. The overall sickness rate for all staff on Sitwell ward was 7% between 10 February 2020 and 16 February 2020. The overall sickness rate for all staff on Spencer North was 5% for the same time period. There was no sickness on Billing Lodge. This was higher than the sickness rate of 4% reported at the last inspection in May 2017.

Managers accurately calculated and reviewed the number and grade of qualified and unqualified nurses for each shift. However, staff told us workchoice and agency staff would regularly not turn up for work, so they ran short staffed.

Ward managers could adjust staffing levels according to the needs of the patients.

Staffing levels allowed patients to have regular one to one sessions with their named nurse.

Staff and managers said patients rarely had their escorted leave, or activities cancelled, even when the service was short staffed. However, five out of 10 patients we spoke with on Spencer North and Sitwell wards told us their leave or activities were cancelled due to not having enough staff.

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

Staff shared key information to keep patients safe when handing over their care to others. We observed multiple visits from staff from another provider who came to visit a patient moving to their care as part of the transition process, as well as a handover being shared with them about her care.

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. We observed medical staff attending the ward to a patient who needed medical attention in a very short space of time after being called.

Staff received and were up-to-date with appropriate mandatory training. Overall, staff in this service had undertaken 93% of the various elements of training that the provider set as mandatory. The provider reported 76% for basic life support, 86% for intermediate life support, 99% for level two safeguarding adults and children and 78% for management of actual and potential aggression training. Billing Lodge had a mandatory training compliance rate below 75% for MAPA initial and refresher programmes. Sitwell ward had a mandatory training compliance rate below 75% for food hygiene level 2 at 66.7%. Spencer North had a mandatory training compliance rate below 75% for

basic life support at 72.7% and immediate life support at 71.4%. The training compliance reported for this core service during this inspection was the same as the previous inspection.

The mandatory training programme was comprehensive and met the needs of staff.

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

Assessing and managing risk to patients and staff

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Staff did not always follow the provider's policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. Staff completed paper observation records detailing the date, time of observation, patient's risk behaviours, patient's location and a signature of the member of staff carrying out the observation.

Staff had not completed observation monitoring forms in line with the providers policy.

We reviewed four patients' observation records over a 24 hour period. We found staff had recorded the wrong date twice, had not recorded the time once and one patient did not have a record of observation on 18 occasions. Staff had recorded the time of observation only 23 times and there were missed signatures on a further 15 occasions.

We found staff recorded the patient's risk behaviour as 'none' most of the time. We found staff had not recorded the page numbers making the sheets very difficult to follow or look back on. We found staff recorded the location of the patient in an initialled key format, but the key was not present on the recording forms so new staff or visitors viewing these records would not be able to easily identify the location of each patient. We found intervals of observation the patient should have been observed was not recorded four out of six times, however, on most observation sheets there was nowhere to record this information. Staff would therefore not know at what intervals patients should be observed. We found the observation time changed even if the patient was still in the same location. The biggest jump we found was from 5 minutes to 30 minutes.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff followed procedures to minimise risks where they could not easily observe patients.

Wards had blanket restrictions in place. Patients on Sitwell ward and Spencer North had to ask staff for a drink and did not have access to the facilities to make their own without staff support. We were told on one ward that patients would throw drinks over each other if they were left out. We were told on another ward that patients would ask staff to make them a drink anyway even if they did have access. Patients were able to carry water bottles with them on Spencer North.

We found further restrictions on Spencer North. The ward had three set vape times where the patients were able to vape in the courtyard. This was particularly low compared to other women's wards where we also found restrictions on vape times. However, staff told us this is regularly reviewed, is being increased to more times a day and this has already been increased on the ward.

This service reported 426 incidences of restraint between 1 September 2019 and 29 February 2020. These were highest on Sitwell ward (322) followed by Spencer North (104). Billing Lodge reported no incidences of restraint. Although overall levels of restraint had reduced since the last inspection, incidences of restraint had increased slightly on Sitwell ward and significantly decreased on Spencer North.

There were 33 incidences of prone restraint from 1 September 2019 and 29 February 2020 which accounted for 8% of all restraint incidents. The highest was on Sitwell ward (30) followed by Spencer North (3). Billing Lodge reported no incidences of prone restraint. Incidences of prone restraint had significantly decreased on both wards since our last inspection.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

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

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

Staff followed National Institute of Clinical Excellence guidance when using rapid tranquilisation. There were 20

incidences of rapid tranquilisation over the reporting period. The highest was on Sitwell ward (12) followed by Spencer North (8). Billing Lodge reported no incidences of administering rapid tranquilisation.

There have been no instances of mechanical restraint over the reporting period.

There had been 65 instances of seclusion from 1 September 2019 and 29 February 2020. The highest was on Sitwell ward (47) followed by Spencer North (18). Billing Lodge reported no incidences of seclusion. Although overall levels of seclusion had significantly reduced since the last inspection, incidences of seclusion had increased by one on Spencer North and significantly decreased on Sitwell ward.

We reviewed eight seclusion records. The seclusion records met most of the requirements of the Mental Health Act Code of Practice. However, we found one example where it was not clear if a medical review had taken place within one hour of the seclusion starting. We found one example where nursing reviews had not taken place by two nurses every two hours throughout seclusion. We found one example where we were unable to find a statement of clinical need, risks and treatment objectives for the seclusion. We found three examples where it was not clear if staff had informed a family member, carer or advocate of the use of seclusion. We also found three examples where it was unclear if staff maintained family or carer contact during the period of seclusion in accordance with the Mental Health Act Code of Practice.

Staff did not follow best practice, including guidance in the Mental Health Act Code of Practice, when a patient was put in long-term segregation.

We reviewed one episode of long-term segregation across the wards for people with learning disabilities and autism. The single episode of long-term segregation had been open for 59 days when we reviewed the records on 5 March 2020 and the patient was still in long-term segregation.

The long-term segregation was recorded as taking place in the seclusion area which would not meet the environmental requirements for long-term segregation in the Mental Health Act Code of Practice. However, when visiting the ward, we observed the patient was not in the seclusion area as records suggested and part of the ward had been segregated for this patient which does meet the environmental requirements for long-term segregation in the Mental Health Act Code of Practice.

There was a thorough assessment and rational for the decision to segregate the patient, with six people involved. There was no independent mental health advocate involved. The use of segregation was authorised by the commissioners prior to the start of the segregation period. The patient's home team were informed. The patient's family and the patient were involved, although the patient was assessed as not having capacity. There was a clear statement about what was required to end the long-term segregation.

There were no hourly observation records for the first two days of long-term segregation. Observation records lacked detail and were often one-word entries. Entries on two observation sheets for one night recorded "Can't be assessed as she is sleeping" on several adjacent hourly observation slots and on the following night "Can't be assessed as she is sleeping" on adjacent hourly observation slots. The provider advised that only one of the forms had been validated and this was the 'true' form. At the time that we reviewed the records (3 March 2020 12:40pm) there were no hourly observation records after the 07:00 to 08:00 box for 3 March 2020. The last entry in the progress notes was 06:57 for 3 March 2020.

None of the multidisciplinary team reviews involved an independent mental health advocate, as per the Mental Health Act Code of Practice.

There were no daily medical reviews for nine days, with telephone reviews on two days.

We were told of an incident where a number of patients contracted methicillin-resistant staphylococcus aureus (MRSA). Senior managers directed that patients should be put into long-term segregation to isolate themselves to stop the spread of an infection. This resulted in unnecessary work including observations and reviews recording for all staff who subsequently failed to follow the principles and guidance of the Mental Health Act Code of Practice.

Most staff understood the differences between long-term segregation and seclusion. However, one staff member told us that long-term segregation is not a punishment, but seclusion would be.

Requires improvement

Wards for people with learning disabilities or autism

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. All staff completed level one and two safeguarding children, young people and adults training on Billing Lodge and Sitwell ward and 96% of staff on Spencer North ward. All staff on Spencer North ward completed level three safeguarding training and 89% of staff from Sitwell ward completed level three safeguarding training. The training compliance reported during this inspection was higher than the 95% reported at the last inspection.

Staff could give clear examples of how to protect patients from harassment and discrimination. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. Each ward had a dedicated family visitors' room within the building which could be booked in advance so managers can ensure staff are available to attend.

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

Staff did not make safeguarding referrals when patients were cared for in long term segregation.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 182 adult safeguarding referrals between 1 February 2019 and 29 February 2020. The largest number of referrals made was on Sitwell ward (97), followed by Spencer North (80) and then Billing Lodge (5).

Staff access to essential information

Patient notes were comprehensive, and all staff could access them easily.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. However, paper enhanced observation records we viewed were not in order and difficult to follow. Administration staff would scan these into the computer system, so they were available to view electronically.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. However, when inspecting the clinic room on Sitwell ward, the staff were unable to gain access to the controlled drugs cupboard. Staff reported this immediately and as a temporary measure the medications stored in this cupboard were moved to a controlled drugs cupboard on another ward until a replacement could be sought.

Staff reviewed patients' medicines regularly and provided specific advice to patients about their medicines. However, one carer said they were unsure what medications their relative was taking but they seemed to be working. One carer told us they were unsure why one of their relative's medications had been stopped.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. All patient medication administration charts are stored on an online computer system. We saw evidence of a business continuity plan should this system fail so staff would still be able to administer patient medications. While visiting Sitwell ward the laptop was broke but staff were able to administer patient medications from the ward office using the office computers which had access to the online medication administration charts.

Staff followed current national practice to check patients had the correct medicines.

Patient allergy information was not easily available. Although we were able to find this on the electronic medication system it did not instantly flag up when administering medication which meant this could easily be missed.

Requires improvement

Wards for people with learning disabilities or autism

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

The service worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff reviewed the effects of each patient's medication on their physical health according to the National Institute of Clinical Excellence guidance.

Track record on safety

Senior managers told us the Women's location reported the highest number of serious incidents across the provider. Between 1 March 2019 and 29 February 2020 there were five serious incidents reported by this core service, three on Sitwell ward and two on Spencer North. Of the total number of incidents reported, the most common type of incident was 'infection control' with two incidents reported of this nature, followed by one each of self-harm, security and physical health.

The number of serious incidents reported during this inspection was lower than the 13 reported at the last inspection across both wards. Billing Lodge had reported no serious incidents.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported serious incidents clearly and in line with the provider's policy.

The service had reported no never events on any wards.

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

Managers debriefed and supported staff after any serious incident. Patients were also debriefed after all incidents where this was appropriate.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff did not always complete a comprehensive mental health assessment of each patient either on admission or soon after. Two out of seven care and treatment records we looked at had ongoing assessments due to the patient being transferred from another ward. One out of the seven care and treatment records we looked at did not have any initial nursing assessment complete as they had been transferred from the community and staff were unable to locate the paperwork.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Positive behaviour support plans were present and supported by a comprehensive assessment. Staff regularly reviewed and updated care plans and positive behaviour support plans when patients' needs changed. Care plans were personalised, holistic and strengths-based.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance (from relevant bodies e.g. National Institute of Clinical Excellence).

Staff understood patients positive behavioural support plans and provided the identified care and support.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required.

Wards for people with learning disabilities or autism

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients.

Managers undertook clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements. This service participated in quarterly clinical audits as part of their clinical audit programme January 2019 to January 2020.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the ward. As well as doctors and nurses, teams included or could access occupational therapists, psychologists, psychology assistants, social workers, social work assistants, associate specialists, pharmacists, speech and language therapists and dieticians.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including workchoice and agency staff. However, managers did not make sure staff received specialist training for their role. Staff told us they had not had specialist learning disability or autism training. Patients told us, and the records show that staff were not trained in supporting transgender patients.

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

Managers supported staff through regular, constructive appraisals of their work.

As of 31 March 2020, the overall appraisal rate for staff within this service was 96%. The ward with the lowest appraisal rate was Spencer North with an appraisal rate of 88%. Sitwell ward and Billing lodge both had an appraisal rate of 100%.

The rate of appraisal compliance reported during this inspection was higher than the 83% for Sitwell ward reported at the last inspection but lower than the 100% reported at the last inspection for Spencer North.

Managers did not always support staff through regular, constructive clinical supervision of their work. The provider's target of clinical supervision is 85% of the sessions required. Between 1 August 2019 and 31 January 2020, the average rate across all wards in this service was 57%. This was highest on Spencer North (63%), followed by Sitwell ward (58%) and then Billing Lodge (50%).

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed one ward round which was well attended, and all aspects of the patients' care and treatment was discussed with the patient.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the service and external agencies.

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. However, staff did not always follow the Mental Health Act Code of Practice in relation to seclusion, long-term segregation and the application of blanket restrictions.

As of 3 March 2020, all staff on Billing Lodge received training in the Mental Health Act and 93% of staff from Sitwell ward and 93% of staff from Spencer North ward received training in the Mental Health Act. The training compliance reported during this inspection was higher than the 75% reported at the last inspection.

Requires improvement

Wards for people with learning disabilities or autism

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

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

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated and recorded it clearly in the patient's notes each time.

Most staff told us they made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. However, one staff member, two patients and two carers told us that sometimes patients cannot go out due to staff shortages.

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

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

As of 03 March 2020, all staff on Billing Lodge received training in the Mental Capacity Act and 93% of staff from Sitwell ward and 93% of staff from Spencer North ward received training in the Mental Capacity Act. The training compliance reported during this inspection was higher than the 75% reported at the last inspection.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act.

Are wards for people with learning disabilities or autism caring?

Inadequate

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with kindness, dignity and respect. Out of the 10 patients we spoke with four patients described some staff as being rude, ignorant and abrupt. One patient told us staff called her an attention seeker. One patient told us staff do not interact with her when they are observing her on her enhanced observations. One patient told us staff interact with each other in a different language which she doesn't understand. Two patients told us staff fall asleep on their enhanced observations. However, the provider advised that there had been no complaints received from patients in regards to staff falling asleep whilst on enhanced observations.

Staff were supporting a number of transgender patients during our visit. Records showed that staff had not completed training to support patients with lesbian, gay, bisexual and transgender needs. Patients told us they felt isolated. We reviewed the records for one patient who identified as male. We noted there was misgendering of the patient throughout their care and treatment record and staff had referred to him as both he and she. According to the provider's Trans-inclusion Policy "the continual use of incorrect names or pronouns is known as misgendering. This has significant impact on the individual and the perpetrator can be prosecuted as part of the Equality Act 2010 as it is acknowledged as a Hate Crime". We noted several occasions throughout the patient's notes where staff used both the patient's preferred male name and previous female name. On these occasions the patients preferred name was put in quotation marks within his notes or in brackets after the patient's previous female name. We reviewed the patients care plans which all clearly stated the patient identifies as male and their preferred name. St Andrews have been notified of this issue in other service inspections.

Not all staff were discreet, respectful, and responsive when caring for patients. We observed one incident where staff were not responsive to a patient's personal hygiene needs.

Requires improvement

Wards for people with learning disabilities or autism

One patient said she felt that not all staff cared about her. One patient told us staff would not give her toilet roll when requested. However, the provider advised that there were several patients at high risk of self harm due to ingestion of toilet paper and are the only patients who would not have free access to toilet roll on request.

Five patients told us they feel safe on the wards. four patients told us staff were kind. Three patients told us staff were respectful. However, two patients told us they do not feel safe. Three patients described the wards as being noisy.

Seven patients told us the wards were short staffed.

Staff used appropriate communication methods to support patients to understand and manage their own care treatment or condition.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff introduced patients to the ward and the services as part of their admission. Staff told us new patients admitted to the ward were given a buddy patient to support their orientation to the ward.

Staff involved patients and gave them access to their care planning and risk assessments. Two patients told us they had a copy of their care plan. Staff made sure patients understood their care and treatment.

Staff involved patients in decisions about the service, when appropriate. The provider introduced a new recruitment process which involved patients as equal partners in deciding on staff to recruit. Staff told us that if patients said a candidate was not suitable, the service would not offer them the job. Two patients told us they had been involved in interviewing staff.

Patients could give feedback on the service and their treatment and staff supported them to do this. We observed a ward round and staff involved the patient in this where appropriate. Patients chaired weekly community meetings on all wards. We observed one of these meetings and reviewed minutes from previous meetings and they were well attended with evidence of active patient involvement.

Staff made sure patients could access advocacy services. Advocacy visited the wards regularly.

Staff did not always keep families or carers informed and involved. One carer told us they don't get regular updates on their relative and they have no way of directly contacting the ward. One carer told us they don't discuss their relatives' activities with them. However, one carer told us they are involved in their relatives' meetings within the service via telecom.

One carer told us it's the best ward her relative had been on. Another carer told us some staff were very helpful.

We spoke to five carers. We asked the provider to give us more carers contact details who we could contact after the on-site inspection. Although the provider was aware we had inspected female wards, the provider gave us carers contact details from the male wards, so we were unable to contact any more carers.

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 for the last 12 months was 92% on Sitwell ward, 83% on Spencer North and 33% on Billing Lodge. Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

The service was commissioned to provide a national facility, with patients from all parts of the United Kingdom and Ireland.

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

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

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

The service had low numbers of delayed discharges in the past year.

Wards for people with learning disabilities or autism

Managers monitored the number of delayed discharges. The proportion of delayed discharges reported during this inspection was the same as the 1 delayed discharge reported at the time of the last inspection. The only reasons for delaying discharge from the service were clinical.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services. We observed staff working with a patient who was being visited by staff from her new placement as part of the transition process. The service followed national standards for transfer.

The facilities promote recovery, comfort, dignity and confidentiality

Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas and had access to a room where patients could meet with visitors in private. However, neither of the wards had access to a sensory room. We were told the wards were moving locations soon and this was something managers were considering as there would be more space. Patients did have access to sensory equipment they could use in other areas of the ward currently.

Patients could make phone calls in private.

The service had an outside space that patients could access easily.

Patients could not make their own hot or cold drinks and snacks and were reliant on staff to unlock areas to allow access or to make these for them. Three patients told us they have to ask staff for drinks. One patient told us they have to wait if staff are busy and staff have told them they have to learn to be patient if they are doing other work.

The service offered a variety of food. Patients we spoke with had mixed opinions on the quality of the food.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients. We were told some patients worked at one of the providers on site cafes and other patients accessed work in the local area.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Staff devised communication plans for patients with communication needs. Staff used social stories and easy read versions of information to support patients.

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

The service could access information leaflets in multiple languages and formats to meet the patient's communication needs. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. Two patients told us that they had access to a priest or vicar who would visit the ward. One patient told us they would like to speak to a priest but had not yet seen one on the ward.

Listening to and learning from concerns and complaints

Patients, relatives and carers knew how to complain or raise concerns.

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

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

Managers investigated complaints and identified themes. However, one patient told us they had not heard anything back from their complaint. One patient told us they have complained but it doesn't get sorted. One carer told us they are still waiting for the outcome of their complaint.

This service received seven complaints during the last 12 months. Sitwell ward received the most complaints (5), followed by Spencer North (2). Billing Lodge received no complaints. The provider told us they have adopted a new approach to focus on the performance around a complaint rather than the outcome of whether it is upheld or not. Their emphasis is on the learning from complaints and what change and quality improvement have been made as a result of the feedback received through concerns and complaints. All complaints are reviewed and reported on with the focus that there is always an opportunity to learn and review procedures such as through understanding the motives and feelings of the person who raised the complaint. No complaints were referred to the Ombudsman.

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

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

This service received six compliments during the last 12 months which accounted for 10% of all compliments received by the women's service. Sitwell ward received the most compliments (4), followed by Spencer North (2). Billing Lodge received no compliments in this time period.

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

Requires improvement

Leadership

Both Sitwell ward and Spencer North had acting ward managers in place. Senior managers had moved ward managers to cover maternity and other temporary posts.

Managers told us they had identified areas for improvement and started to address these. We identified there was work to be done in ensuring staff always treated patients with dignity and respect.

Patients and staff knew senior managers, said they were very visible and could approach them with any concerns.

Vision and strategy

The provider's vision was to Transform Lives Together. The values which underpin this vision and strategy were: Compassion: Be supportive; understand and care for our patients, their families and all in our community. Accountability: Take ownership; be proactive, be responsible, do what you say you will do. Respect: Act with integrity; be real, be open, be honest. Excellence: Innovate, learn and deliver; whatever you do, do it well.

Although the provider's senior leadership team successfully communicated the provider's vision and values to the frontline staff in this service, staff did not always embed them in practice. Senior managers told us there was a focus on role modelling the values and managing staff that did not demonstrate them in their work. The vision and values were discussed weekly in ward memo's and monthly within the wider learning disability core service memo's and we saw examples of these for both wards.

Culture

Staff we spoke with said they felt respected, supported and valued they confirmed that managers kept them informed of changes that would affect them through ward memo's and red top alerts. However, staff did not receive specific support to work in a learning disability service and were not supported regularly through planned and consistent supervision.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process if they needed to.

Managers did not always deal with poor staff performance when needed. Issues remained with some staff not always treating patients with dignity and respect and with how staff ensured a safe and clean environment.

Requires improvement

Wards for people with learning disabilities or autism

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. However, we found concerns in this core service relating to how staff cared for transgender patients.

We saw in monthly core service memo's that staff success was celebrated in line with the provider's vision and values and staff won prizes and certificates monthly and quarterly. Monthly core service memo's also updated staff on core service updates, team updates, training and opportunities, lessons learned and red top alerts, compliance and clinical focus for the following month.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear framework of what must be discussed at a ward and senior management team level meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

We were told staff carried out audits of care plans. However, these audits were not effective in identifying the misgendering of a patient throughout their care plan.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Managers had the opportunity to discuss the risk register with staff within meetings, staff then discussed these with patients. Staff at ward level could escalate concerns when required.

Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

Staff had access to the equipment and information technology needed to do their work.

Staff made notifications to external bodies as needed.

Engagement

Staff and patients had access to up-to-date information about the work of the provider and the services they used through weekly ward memo's and monthly core service memo's. These were sent via email to all staff.

Managers took time to engage with staff to give them the opportunity to contribute to discussions about the strategy for their service.

Patients had opportunities to give feedback on the service they received in weekly community meetings and one to one sessions with their named nurse.

Learning, continuous improvement and innovation

The provider had implemented a new quality improvement approach. Quality improvement leads were visiting wards and speaking to staff about innovations and how to embed these and learn from them. The focus was on getting staff to own their ideas. All staff were committed to continually improving the service and had a good understanding of quality improvement methods.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff treat patients with kindness, respect and dignity at all times, including use of appropriate language and when supporting transgender patients. (Regulation 10 (1))
- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure that staff use approved restraint techniques in line with the provider's policy and protocol. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must review the use of restrictive interventions and act to reduce the use of restraint. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that staff follow the Mental Health Act Code of Practice in relation to seclusion, long term segregation and blanket restrictions. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that robust and effective handovers take place, between staff shifts, to ensure that information about risk and patients' care is communicated between relevant teams, to support patient safety. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that handovers are recorded in line with policy. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff provide required physical health interventions in a timely manner. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure staff report and record all incidents appropriately, notifying external agencies when required. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that the environment is well maintained, safe and clean. (Regulation 12 (1) (2) (a) (b) (d))
- The provider must ensure staff complete individual risk assessments and care plans for all patients. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure the proper and safe management of medicines. (Regulation 12 (1) (2) (g)
- The provider must ensure that leadership and governance arrangements support the delivery of high quality, person centred care, operate effectively and address risk issues. (Regulation 17 (1) (2) (a) (b))
- The provider must ensure that wards are staffed with the required numbers of suitably skilled staff. (Regulation 18 (1))
- The provider must ensure that managers regularly supervise staff and provide them with an annual appraisal. (Regulation 18 (2) (a))
- The provider must ensure that staff receive the required specialist training to carry out their roles effectively. (Regulation 18 (2) (a))
- The provider must ensure that they notify the Care Quality Commission of all notifiable incidents and safeguarding concerns. (Regulation 18 (Registration) Regulations (2) (e))

Action the provider SHOULD take to improve

- The provider should ensure they respond to all patient complaints in line with policy and procedure.
- The provider should ensure that patient care plans that relate to eating disorders are effective.
- The provider should ensure staff have access to regular team meetings and communications.
- The provider should update ligature assessments when changes to the ward areas are made.
- The provider should action audit findings and resolve them at the earliest opportunity.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents • **Managers did not always make notifications to the Care Quality Commission when safeguarding incidents occurred.** This was a breach of regulation 18

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Managers had not ensured established optimum (ideal) staffing levels on all shifts. The provider reported that 12% of shifts were unfilled between 01 February 2019 and 31 January 2020. The provider reported 13 forensic service failure incidents due to staff shortages between 01 September 2019 and 29 February 2020. Patients and staff told us that staff shortages often resulted in staff cancelling escorted leave, hospital appointments and activities across all core services. • Managers did not ensure all staff received appraisal and supervision. Between 01 August 2019 and 31 January 2020, the average clinical supervision rate across forensic wards was 73%. Between 01 August 2019 and 31 January 2020, the average appraisal rate across forensic wards was 54%. For the learning disability service supervision rates across all wards was 57%. • Managers on the learning disability wards and forensic wards did not make sure staff received specialist training for their role including learning disability, autism training or transgender training. This was a breach of regulation 18

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • Staff did not always treat patients with kindness, dignity and respect. Staff at the forensic service used derogatory and inappropriate language to describe patients. Staff at the learning disability service misgendered patients. Staff at the long stay rehabilitation service did not always uphold patients' dignity in relation to medication and care. In the psychiatric intensive care service, staff described patient's behaviour in seclusion as 'new tricks'. This was a breach of regulation 10

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Staff did not always support patients' physical health needs effectively at the long stay rehabilitation and forensic services. We reviewed incidents where staff had not provided physical health interventions as required and staff did not always record patient's physical health or nutritional needs. • Patients alleged that staff on Sunley ward used inappropriate restraint techniques. Levels of restraint significantly increased since the last comprehensive inspection across the forensic service. Staff did not always record details of restraint techniques used. • Staff did not always share clear information about patients and any changes in their care. Staff in the forensic service did not always complete handovers in line with the provider's policy and procedures. We

found examples of poor record keeping of handovers. Staff arrived late to handovers. Staff were not completing risk assessments on Elgar ward, with information being copied between records for different patients.

- Staff did not always follow the Mental Health Act Code of Practice in relation to seclusion, long term segregation and blanket restrictions.
- We were concerned that staff were not reporting all safeguarding concerns to the local authority safeguarding team at the forensic and psychiatric intensive care services. Staff at these services were not reporting all incidents and not recording all incidents appropriately.
- Managers did not ensure safe and clean environments in the long stay rehabilitation service and learning disability service. Staff did not learn from cleanliness audits. Staff had not completed the Elgar ward ligature risk assessment. We observed mixed bags of unlabelled laundry on Sitwell ward. Facilities and premises used on Elgar and Spring Hill wards were not appropriate for the service being provided.
- Staff failed to maintain reliable systems, processes and practice around medicine management. We found issues with inappropriate storage of medicines, staff not labelling opened medications, patient allergy information and a significant medication error.

This was a breach of regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The leadership and governance did not always support the delivery of high quality, person centred-care. The provider’s governance processes had not addressed staff failures to follow the provider’s procedures. Leaders did not always understand the issues, priorities and challenges the forensic and long stay rehabilitation

Enforcement actions

services faced. We were not assured that leaders had taken sufficient action to address concerns raised during the focused inspection of the forensic service in January and February 2020.

This was a breach of regulation 17