St Andrew's Healthcare: Women's, Men's, Adolescent and Neuropsychiatry services.

Quality Report

St Andrew's Healthcare,
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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	Requires improvement
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

Summary of findings

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.

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

Overall summary

We rated St Andrew's Healthcare Northampton as requires improvement because:

- Not all seclusion rooms considered the privacy and dignity of patients. Staff used closed circuit television (CCTV) to monitor patients. However, monitors were visible to staff from the office and to patients on entering or leaving the adjacent low stimulus room. In adolescent services, one seclusion room had a faulty two-way intercom system. Care records confirmed that the room was used regularly and recently. In older adults services the provider did not always reduce the risk from blind spots.
- In forensic services, the receptionist controlled access to three buildings from one reception area and used CCTV monitors to control access. When reception staff were away from their desk, access to the building was delayed for patients.
- On Seacole ward there were issues with controlling temperatures on the ward. This was because of the air exchange system sending columns of cold air directly downwards when the ward gets above 28 degrees. The provider told us they were going to fit a safe diffuser over all of the ducts to try to diffuse the cool air over a larger area. On Seacole ward, the furniture in the night lounge was torn and dirty. In the psychiatric intensive care unit (PICU) some bedrooms, bathroom and shower areas were dirty and carpets were not clean. We could detect a strong smell of urine in some bedrooms. The shower areas upstairs did not provide comfort or promote dignity and privacy. There was a shower curtain on some, but not all showers. The door to the room did not lock and patients needing the toilet could enter. We observed staff searching patients in communal areas on two wards. One ward lacked appropriate signage and other relevant information for patients with neuro rehabilitation needs. Staff restricted access to patients wishing to use their bedrooms, and this was not individually risk assessed.
- There were ligature points in the psychiatric intensive care unit and the provider did not ensure all patients' risk assessments and care plans included the management of specific environmental ligature risks. There was no recorded evidence of staff and patients having an immediate debrief following an incident. A debrief is an opportunity for staff to reflect on the incident, review what action was taken, any immediate lessons learned and to offer support to patients and staff.
- The provider had high vacancy rates in forensic, neuropsychiatry, older adults and rehabilitation services. This was particularly high for registered nurses. The provider used bureau (St Andrew's bank staff) and agency staff to fill vacant shifts. However, a significant number of shifts remained unfilled. Staff told us when shifts were not filled, staff moved between wards to meet patient need or wards worked short of staff. Staffing levels at night were particularly low.
- In rehabilitation, adolescent and forensic services, staff did not always complete physical healthcare monitoring following administration of rapid tranquilisation or commencement of seclusion. Staff did not always complete physical healthcare

monitoring for patients prescribed specific medications and staff did not complete the relevant chart regularly or appropriately. Staff in forensic services did not always document fully what patients had been offered or received. There were gaps in records where staff had not signed the entries. In rehabilitation services, staff did not always respond appropriately to a decline in a patient's physical health and did not use observation tools to review and assess the response needed.

- Not all staff had completed training in the Mental Health Act (MHA) or the Mental Capacity Act (MCA). Staff did not receive annual MHA training and the provider could not demonstrate that staff had received training in the revised MHA code of practice. This meant that staff were not working to the most recent guidelines. Staff did not read patients their rights under section 132 of the Mental Health Act in some wards. If patients did not understand their rights, staff did not always make further attempts. On PICU, forensic, rehabilitation and older adult's wards staff had not uploaded the MHA legal detention papers in full to the electronic system. Some records had part of the paperwork uploaded.
- In some services staff did not assess patient's capacity to consent to treatment appropriately. Staff documented patients did not have capacity but did not give a rationale as to why they had made this decision nor document any discussion. Mental capacity assessments were not decision specific. Consultants did not always accurately complete medication consent paperwork (T2 and T3 forms). Staff kept some information in paper format.
- The provider did not have an effective management supervision structure. Supervision was highlighted as an issue in learning disabilities, older adults and rehabilitation services. Supervisions occurred monthly by peers rather than line managers in some areas. We saw that some staff had different supervisors each month. This meant there was no consistency and managers could not be sure that supervisors were addressing performance issues.
- Not all groups of staff felt engaged with the developments and changes to the service.

However:

- There had been improvements since the last inspection. Leadership had been strengthened and new ways of working implemented to improve the patient experience. The provider had improved governance systems and carried out recruitment drives to attract staff. There had been an overall decline in the use of agency staff over the preceding 12 months.
- Most wards were safe, visibly clean, homely and well furnished. Patients could access garden areas and open spaces. Patients held their own mobile phones wherever possible and had private access to a landline telephone that had direct lines to advocacy and other services. Wards had a range of rooms for care and treatment and rooms for patients to meet visitors in private. Wards had seclusion rooms, low stimulus rooms and extra care suites for patient use. Patients could personalise their bedrooms and had lockable spaces to secure possessions. The provider had procedures for children visiting. Staff provided a range of activities for patients and activities were available seven days a week.
- On most wards, staff updated patients' risk assessments regularly and included patients' individual needs. Staff in forensic services completed regular ligature risk assessments and wards contained very few ligature risks. Staff managed known risks with nursing observations and individual risk assessments. Staff had quick access to ligature cutters and pocket masks (for use in mouth to mouth resuscitation) in different areas of the wards. Staff used positive behavioural support plans with patients effectively.
- Staff undertook comprehensive assessments and developed care plans that were thorough, holistic and patient centred. With the exception of rehabilitation, adolescent and forensic services, staff monitored the physical health of patients regularly and developed physical health goals and treatment for patients. Staff used outcome measures such as health of the nation outcome scale and specific tools for acquired brain injury patients. Physical healthcare services included dentistry and podiatry. Practice nurses from the GP surgery attended the wards to address patients' physical healthcare needs. Staff made prompt referrals for any further specialist physical healthcare input.
- Staff were passionate about their job and knew patients well. Patients told us staff worked hard and were kind to them. Most staff treated patients with dignity and respect and were responsive to patients' individual needs.

Summary of findings

- We saw leadership at ward manager level. Managers said they felt supported and staff said they felt valued. Senior staff monitored incidents and discussed outcomes in team meetings. Some senior staff gave examples of learning from incidents for their ward. Staff told us morale was increasing following a period of change over the last two years and told us their managers were supportive. Multidisciplinary teams worked effectively across all wards.
- The provider had ongoing recruitment and retention programmes to attract new staff. Staff received training in safeguarding and made appropriate referrals. There was a range of psychological interventions available for patients which patients were encouraged to attend. Staff trained in British sign language (BSL) were available to patients on Fairbairn ward. The provider had an induction programme for new staff and was supportive of further learning opportunities for all permanent staff. Staff received annual appraisals and most staff received regular supervision. Staff attended regular team meetings and recorded any actions and outcomes from these.
- In some wards, Mental Health Act 1983 (MHA) paperwork was in order and stored securely. MHA administrators had a thorough scrutiny process. Some staff used the Mental Capacity Act to assess capacity for individual decisions. There were appropriate systems for managing and recording complaints. Patients had access to independent advocacy services. This meant that they were able to receive independent support to help them express their views and assist with any appeal against their detention under the MHA if they so wished.
- Managers had access to dashboards for their teams, which gave details of staff compliance with mandatory training. Nurse managers reported they received prompts from the provider's training department when staff's mandatory training or refreshers were due.
- The provider managed quality and safety using a variety of tools. There was a dashboard for monitoring ward performance, quality and safety against agreed targets. There was a monthly lessons learnt bulletin for staff. Staff told us they knew the whistleblowing policy and felt they could raise concerns without fear of victimisation. Managers were visible on the wards and staff felt supported by operational managers and clinical nurse leads.
- The managers told us, and we saw the documents to show, they were offering an 'Aspire campaign', which supported healthcare support workers to undertake their nurse training. The provider would pay these staff a bursary to support their training, following which they would return to work at St Andrew's for a minimum of two further years. The provider had plans to support 20 staff a year in this scheme.

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 	• Sherwood ward is the psychiatric intensive care unit.
Forensic inpatient/ secure wards	Requires improvement 	• Seacole Ward is a medium secure ward for women. • Stowe Ward is a medium secure ward for women. • Sunley ward is a medium secure ward for women. • Elgar ward is a low secure ward for women. • Spencer South is a low secure ward for women. • Sinclair ward is a low secure ward for women. • Robinson ward is a medium secure ward for men. • Fairbairn is a medium secure ward for men with hearing difficulties. • Prichard ward is a medium secure ward for men.
Long stay/ rehabilitation mental health wards for working-age adults	Good 	• Thornton ward is a locked rehabilitation unit for women. • Ferguson ward is a locked rehabilitation unit for men. • Spring Hill House is a locked facility rehabilitation unit for Women offering 23 beds.
Child and adolescent mental health wards	Good 	• Bayley ward is a medium secure inpatient ward that can

Summary of findings

accommodate up to 10 children and adolescent males with learning+ disabilities / autistic spectrum disorder.
- Heygate ward is a medium secure inpatient ward that can accommodate up to 10 children and adolescent males with learning disabilities / autistic spectrum disorder.
- Fenwick ward is a low secure inpatient ward that can accommodate up to 10 children and adolescents females with neuro-disability / autistic spectrum disorder.
- Richmond Watson ward is a low secure inpatient ward that can accommodate up to 12 children and adolescent males with complex mental health needs.
- Church ward is a low secure inpatient ward that can accommodate up to 10 children and adolescent males with neuro-disability / autistic spectrum disorder.
- Boardman ward is a low secure inpatient ward that can accommodate up to 11 children and adolescent females with complex mental health needs.
- Heritage ward is a low secure inpatient ward that can accommodate up to 12 children and adolescent females with complex mental health needs.
- John Clare ward is a low secure inpatient ward that can accommodate up to nine children and adolescent females with complex mental health needs.

Wards for older people with mental health problems

Good

- O'Connell ward is a locked ward for male older adults.
- Compton is a locked ward for male and female older adult patients.

Summary of findings

- Foster is a locked ward for male older adults.
- Cranford is a medium secure ward for male older adult patients.

Wards for people with learning disabilities or autism

Good 

- Hawkins is medium secure ward for men with learning disabilities (LD).
- Sitwell is a medium secure ward for women with LD.
- Naseby is a low secure ward for men with LD.
- Spencer North is a low secure ward for women with LD.
- Mackaness is a male medium secure ward for people with ASD.
- Harlestone is a male low secure ward for people with ASD.

Services for people with acquired brain injury

Good 

- Rose ward is a medium secure male ward.
- Tallis, Tavener, Althorp, Berkeley Close (1st floor) are male locked wards.
- Berkeley Close (ground floor) is a female locked ward.
- Berkeley Lodge, 37 and 38 Berkeley Close and 19 The Avenue are locked units
- Walton is for male patients with Huntingdon's disease.
- Harper – specialist ward for male and female patients with Huntingdon's disease.

Summary of findings

Contents

Requires improvement

St Andrew's Healthcare Northampton

Services we looked at:

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults; Child and adolescent mental health wards; Wards for older people with mental health problems; Wards for people with learning disabilities or autism; Services for people with acquired brain injury (Neuropsychiatry).

Summary of this inspection

Background to St Andrew's Healthcare

St Andrew's Northampton has been registered with the CQC since 11 April 2011. The services have a registered manager and a controlled drug accountable officer. The registered locations at Northampton are adolescent services, men's services, women's services and neuropsychiatry services. We inspected all locations during this inspection. St Andrew's Healthcare Northampton is a large site consisting of more than ten buildings, more than 50 wards and has 659 beds.

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

The locations at St Andrew's Healthcare Northampton have been inspected 18 times. The last inspection was in September 2014. The CQC identified issues in relation to several aspects of care. The provider was compliant during this inspection unless otherwise stated in the section "action we have told the provider to take". There had been previous visits to the wards by Mental Health Act reviewers. We considered these in preparation for this inspection.

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

The following core services were inspected:

Wards for people with learning disabilities or autism:

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

- Hawkins ward, a 15 bed medium secure service for men with learning disabilities and forensic challenging behaviour.
- Sitwell ward, a 14 bed medium secure service for women with learning disabilities and /or autistic spectrum conditions.
- Harlestone ward, a 20 bed male low secure ward for people with autistic spectrum disorder.
- Spencer North ward, a 15 bed low secure service for women with learning disabilities and/or autistic spectrum conditions.
- Naseby ward, a 15 bed service for men with mild/ borderline learning disabilities.
- Mackaness ward, a 15 bed a male medium secure ward for people with autistic spectrum disorder.

At the time of our visit, each ward was at full capacity and 94 patients were in treatment. There was one patient on Naseby ward and one on Hawkins ward who were receiving extra care.

Forensic inpatient/secure wards:

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

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

The female pathway includes both medium and low secure wards:

- Seacole Ward is a medium secure ward with 15 beds.
- Stowe Ward is a medium secure ward with 13 beds.
- Sunley ward is a medium secure ward with 14 beds.
- Elgar ward is a low secure ward with 12 beds.
- Spencer South is a low secure ward with 14 beds.
- Sinclair ward is a low secure ward with 14 beds.

The male pathway has medium secure wards:

- Robinson ward is a medium secure ward with 17 beds.
- Fairbairn is a medium secure ward with 15 beds and caters for patients with hearing difficulties.
- Prichard ward is a medium secure ward with 15 beds.

From the last inspection the provider had failed to meet regulations, which they were required to address:

- On Fairbairn ward, Inspectors found staff trained in British Sign Language (BSL) were moved off the ward to cover staff shortfalls on other wards. This resulted in

loss of skilled staff able to communicate with patients. Inspectors found Fairbairn ward was fully staffed during this inspection. On this inspection, staff told us they continued to support other wards when their staffing was low.
- Patients on Fairbairn ward were not receiving information on patients' rights in a format they could understand. The provider was found to be compliant during this inspection.
- Patients in the men's service did not consistently have documented discharge plans. During this inspection, we found discharge plans completed for patients.

Wards for older adults with mental health problems:

There are four wards at the Northampton site providing older adult services. Three of the wards were single sex, and the forth provided mixed sex accommodation. Wards at the site follow care pathways as patients progress with their recovery.

Wards for older adults include:

- O'Connell ward is a 23 bed a locked ward for male older adults.
- Compton ward is a 18 bed locked ward for both the male and female patients.
- Cranford ward is a 17 bed medium secure ward for male patients.
- Foster ward is a 15 bed a low secure ward for male older adults.

Psychiatric intensive care unit (PICU):

Sherwood ward is a 12 bedded, male only psychiatric intensive care unit. During inspection, all twelve beds were in use and all patients were detained under the Mental Health Act.

Acquired brain injury (Neuropsychiatry) services:

Specialist neuro-rehabilitation inpatient services for men and women are provided as a separate service within the main hospital site.

The service provides assessment and treatment for patients with complex neurological needs following a traumatic or acquired brain injury, including those with a forensic history detained under the Mental Health Act. The service also offers care and treatment for patients with Huntingdon's disease and Korsakoffs syndrome.

The neuropsychiatric service comprises nine wards and three rehabilitation community based houses:-

- Tavener – with16 beds including four self-contained flats for male patients.
- Tallis – with 14 beds and an extra care suite for male patients.
- Rose – with 17 beds in a medium secure environment for male patients.
- Althorp – with 18 beds for male patients.
- Berkeley Close first floor – with 15 beds for male patients.
- Berkeley Close ground floor – with 14 beds for female patients.
- Berkeley Lodge – with six beds for male and female patients.
- Numbers 37 and 38 Berkeley Close and 19 The Avenue.
- Walton – 14 beds for male patients with Huntingdon's disease.
- Harper – specialist ward with11 beds for male and female patients with Huntingdon's disease.

There were 114 patients receiving assessment and treatment in this service during our inspection. Of these 103 were detained under the Mental Health Act, five were subject to Deprivation of Liberty Safeguards and six were informal patients.

Long stay/rehabilitation wards for working age adults:

There are three wards providing rehabilitation support to patients:

- Thornton ward provides support for up to 15 female patients in a locked rehabilitation environment. At the time of inspection there were 15 patients receiving care and treatment on the ward.
- Ferguson ward provides support for up to 15 male patients in a locked rehabilitation environment. At the time of inspection there were 14 patients receiving care and treatment on the ward.
- Spring Hill House is a locked unit which provides specialist support to female patients diagnosed with borderline personality disorder. The ward has 23 beds. At the time of the inspection, 13 people were receiving care and treatment on the ward. Spring Hill House is a progressive environment that offers different types of accommodation and observation based on patient risk.

Summary of this inspection

Patients are able to progress to Spring Hill House from Seacole and Spencer South wards, which are medium and low secure wards at St Andrew's Healthcare Northampton. Patients can be admitted directly to Spring Hill House. Pre-discharge work takes place to integrate patients back in to the community.

Child and adolescent mental health wards:

St Andrew's healthcare offers low and medium secure specialist services for children and adolescents with mild/ moderate learning disabilities, autistic spectrum disorder, challenging behaviours and individuals who may have a mental health problem and offending history. They offer care and treatment to children and adolescents who may have a neuro-disability.

There is a bespoke service for an individual within the grounds. We visited each of the nine wards throughout the inspection:

- Bayley ward is a medium secure inpatient ward that can accommodate up to 10 children and adolescent males with learning disabilities / autistic spectrum disorder.
- Heygate ward is a medium secure inpatient ward that can accommodate up to 10 children and adolescent males with learning disabilities / autistic spectrum disorder.
- Fenwick ward is a low secure inpatient ward that can accommodate up to 10 children and adolescent females with neuro-disability / autistic spectrum disorder.
- Richmond Watson ward is a low secure inpatient ward that can accommodate up to 12 children and adolescent males with complex mental health needs.
- Church ward is a low secure inpatient ward that can accommodate up to 10 children and adolescent males with neuro-disability / autistic spectrum disorder.
- Boardman ward is a low secure inpatient ward that can accommodate up to 11 children and adolescent females with complex mental health needs.
- Heritage ward is a low secure inpatient ward that can accommodate up to 12 children and adolescent females with complex mental health needs.
- John Clare ward is a low secure inpatient ward that can accommodate up to nine children and adolescent females with complex mental health needs.
- Glendale unit is a bespoke service for one male adolescent.

This facility is able to offer education opportunities for young people through St Andrew's college. The college is Ofsted registered and rated as outstanding.

The last inspection took place September 2014 (Published 10 February 2015) on the adolescent, men's, neuropsychiatry and women's services. This was part of a pilot to determine if independent providers could be inspected in the same way as NHS providers. St Andrew's was given draft ratings at that point. It has since been determined that independent providers will not be inspected in the same way as NHS so this inspection was the first for St Andrew's Northampton using the independent inspection methodology.

Our inspection team

Team leader: Margaret Henderson, Inspection Manager, mental health hospitals, CQC.

The team that inspected the location consisted of four inspection managers, eleven inspectors, a member of the medicine management team and a variety of specialists including consultant psychiatrists, mental health nurses, psychologists, social workers, occupational therapists and experts by experience. Experts by experience are people who have experience of using services or for caring for someone who has used services.

The team would like to thank all those who met and spoke with the team during the inspection, and were open and balanced with the sharing of their experiences, and their perceptions of the quality of care and treatment at this location.

Summary of this inspection

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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.

We carried out an unannounced inspection on 22 June 2016 to William Wake House and Spring Hill House.

During the inspection visit, the inspection team:

- visited 41 wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 167 patients who were using the service
- spoke with nine carers of patients who use the service
- spoke with the registered manager and nurse managers or acting managers for each of the wards
- spoke with 174 other staff members; including doctors, nurses, occupational therapists, psychologists and social workers and facilitated seven focus groups with different groups of staff including nurses, psychiatrists, healthcare assistants and administration staff
- attended and observed eight review meetings
- looked at 192 care and treatment records of patients
- carried out a specific check of the medication management on all wards visited and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 167 patients receiving care and treatment from the service and nine carers of patients receiving care and treatment.

Overall, patients felt they had good relationships with staff and said staff worked hard. Patients reported that regular staff were compassionate and caring. However many patients told us they found bureau and agency staff less approachable.

Patients told us they felt safe on the wards but sometimes when other patients were distressed they could be loud and disruptive. Some patients said activities were cancelled when there was not enough staff and others said staff made every effort to provide planned activities.

Most patients told us the activities were good and they were well supported by the occupational therapists and psychologists. Some patients in neuropsychiatry said they were bored at times.

Some patients said that when their ward was short of staff they could not always go to their bedrooms when they wanted as rooms were upstairs and staff could not always support this. They also said access to facilities might be affected, for example access to the washing machine to do their laundry.

Patients said they were involved in planning their care and had opportunity to discuss concerns in multidisciplinary meetings. Patients told us they could provide feedback through their community meetings and they were aware of the process to make a complaint.

Summary of this inspection

Some patients told us they could not access drinks when they wanted. However, they said staff offered drinks throughout the day.

Carers told us they felt staff took a genuine interest in the recovery of patients and were kind, helpful and respectful. All carers said they felt their loved one was happy and had made some progress in their treatment since being at St Andrew's.

Three out of six patients on the psychiatric intensive care unit said the ward was not always clean.

Some patients commented on the recent closure of Glendale Cottage and that they felt this was reducing their ability to move on. However, Glendale had become part of the adolescent pathway and patients may not have been aware of this.

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?

Good

- Not all seclusion rooms considered the privacy and dignity of patients. Staff used closed circuit television (CCTV) to monitor patients. However, the monitors were visible to staff from the office and to patients on entering or leaving the adjacent low stimulus room. In adolescent services, one seclusion room had a faulty two-way intercom system and wiring was exposed. The provider assured us this in no way hindered communication with young people who were being secluded. The provider stated staff and patients could be heard very clearly without the intercom and the intercom was purely there to enhance this communication. Care records confirmed that the room was used regularly and recently. In older adults services the provider did not always reduce the risk from blind spots. There were ligature points in the psychiatric intensive care unit.
- In forensic services, the receptionist controlled access to three buildings from one reception area and used CCTV monitors to control access. When reception staff were away from their desk, access to the building was delayed for patients.
- On Seacole ward there were issues with controlling temperatures on the ward. This was because of the air exchange system sending columns of cold air directly downwards when the ward gets above 28 degrees. The provider told us they were going to fit a safe diffuser over all of the ducts to try to diffuse the cool air over a larger area. On Seacole ward, the furniture in the night lounge was torn and dirty. In the psychiatric intensive care unit (PICU) some bedrooms, bathroom and shower areas were dirty and carpets were not clean. We could detect a strong smell of urine in some bedrooms. There was a shower curtain on some, but not all showers. The door to the room did not lock and patients needing the toilet could enter. One ward lacked appropriate signage and other relevant information for patients with neuro rehabilitation needs. Staff restricted access to patients wishing to use their bedrooms, and this was not individually risk assessed. Staff reported that the decision to restrict access was in part due to the environment, staffing and the bedrooms being upstairs. Supporting patients to access their bedroom upstairs affected the availability of activities in other areas of the ward.
- In the PICU the staff did not ensure all patient risk assessments and care plans included the management of specific

environmental ligature risks. The provider did not ensure all patients' risk assessments and care plans included the management of specific environmental ligature risks. There was no recorded evidence of staff and patients having an immediate debrief following an incident. A debrief is an opportunity for staff to reflect on the incident, review what action was taken, any immediate lessons learned and to support patients and staff.

- The provider had high staff vacancy rates in forensic, neuropsychiatry, older adults and rehabilitation services. This was particularly high for registered nurses. The provider used bureau and agency staff to fill vacant shifts. However, a significant number of shifts remained unfilled. Staff told us when shifts were not filled; staff moved between wards to meet patient need or wards worked short of staff. Staffing levels at night were particularly low. Twenty-four patients told us that staff cancelled activities when staffing was low.
- The provider was introducing a new training programme for dealing with aggression and violence. This resulted in staff having been trained in different methods of physical restraint. Staff told us different techniques were being used, which had resulted in confusion between staff members when carrying out restraint. We were concerned that this might result in injury to patients or staff.

However:

- Most wards were safe, visibly clean, homely and well furnished. Patients could access garden areas and open spaces. Patients held their own mobile phones wherever possible and had private access to a landline telephone that had direct lines to advocacy and other services. Wards had a range of rooms for care and treatment and rooms for patients to meet visitors in private. Wards had seclusion rooms, low stimulus rooms and extra care suites for patient use. The provider had procedures for children visiting.
- On most wards, staff updated patients' risk assessments regularly and included patients' individual needs. Staff managed known risks with nursing observations and individual risk assessments. Staff had quick access to ligature cutters and pocket masks (for use in mouth to mouth resuscitation) in different areas of the wards. Each ward had a ligature risk audit and ligature risks were identified and documented (ligature points are fittings to which patients intent on self-injury might tie something to harm themselves). There were environmental

Summary of this inspection

risk management plans in place to address any identified concerns. On most wards, staff had mitigated risks by the use of observation mirrors and enhanced observation levels in ward areas that could not easily be seen by staff.

- The provider had implemented ongoing recruitment and retention programmes to attract new staff. There had been an overall decline in the use of agency staff over the preceding 12 months. Staff received training in safeguarding and made appropriate referrals with support from the ward social workers to refer concerns to the local authority. Staff attended regular team meetings and recorded any actions and outcomes from these.
- Most staff we spoke with knew how to report incidents. There were opportunities for shared learning across the provider. Staff knew what situations required reporting as incidents, and investigations took place to identify learning.
- The provider maintained equipment and kept cleaning records. Staff completed regular checks to ensure equipment was in good working order. Staff had access to appropriate alarms. The provider had effective medicines management processes and medication was stored correctly. Clinic rooms were well equipped and organised.

Are services effective?

Requires improvement

- In rehabilitation, adolescent and forensic services, staff did not always complete physical healthcare monitoring following administration of rapid tranquilisation or commencement of seclusion. Staff in forensic services staff did not always ensure records detailed patients being offered or receiving adequate diet or fluids. Records were not always signed and detailed. Staff did not always complete physical healthcare monitoring for patients prescribed specific medications and staff did not complete the relevant charts.In rehabilitation services staff did not always respond to a decline in a patient's physical health and staff did not use observation tools to review and assess the response needed.In the forensic and adolescent service staff did not always complete physical healthcare monitoring for patients prescribed high dose antipsychotic medication.In the adolescent service, the use of rapid tranquillisation did not follow the National Institute for Health and Care Excellence (NICE) guidelines.
- Not all staff had completed training in the Mental Health Act (MHA) or the Mental Capacity Act (MCA). Staff did not receive annual MHA training and the provider could not demonstrate that staff had received training in the revised MHA code of

practice. This meant that staff were not working to the most recent guidelines. Staff did not upload the MHA legal detention papers in full to the electronic system. Some records had part of the paperwork uploaded. One set of paperwork had not been uploaded at all and the patient had been on the ward for over two months. This meant that staff were unable to access the information and therefore could not verify a patient's legal status via the patient's records. Nurse managers relied on the provider's training department for prompts when training was due for their staff. Staff did not read patients their rights under section 132 of the Mental Health Act in some wards. If patients did not understand their rights, staff did not always make further attempts to do this.

- In some services staff did not assess patient's capacity to consent to treatment appropriately. Staff documented patients did not have capacity but did not give a rationale as to why they had made this decision nor document any discussion. Mental capacity assessments were not decision specific. Consultants did not always accurately complete medication consent paperwork (T2 and T3 forms). Care records in rehabilitation services were sometimes difficult to navigate and information was stored in different sections of the electronic system across the service. Staff kept some information in paper format.
- The provider did not have an effective management supervision structure. Supervision was highlighted as an issue in learning disabilities, older adults and rehabilitation services. Supervisions occurred monthly by peers rather than line managers. We also saw that some staff had different supervisors each month. This meant there was no consistency and managers could not be sure that supervisors were addressing performance issues.

However:

- Staff undertook comprehensive assessments and developed care plans that were thorough, holistic and patient centred. With the exception of rehabilitation, adolescent and forensic services, staff monitored the physical health of patients regularly and developed physical health goals and treatment for patients. Staff used outcome measures such as health of the nation outcome scale and specific tools for acquired brain injury patients. Physical healthcare services included dentistry and podiatry. Practice nurses from the GP surgery attended the wards to address patients' physical healthcare needs. Staff made prompt referrals for any further specialist physical healthcare input.

Summary of this inspection

- In some wards Mental Health Act (MHA) paperwork was in order and stored securely. MHA administrators had a thorough scrutiny process. Patients detained under the Act had their rights read to them regularly and paperwork was in order and stored appropriately. Some staff used the Mental Capacity Act to assess capacity for individual decisions. Patients had access to independent advocacy services. This meant that they were able to receive independent support to help them express their views and assist with any appeal against their detention under the MHA if they so wished. There were appropriate systems for managing and recording complaints.
- The provider supported healthcare support workers to complete extra training or to attend university to qualify as registered nurses. There was a clear career pathway for nurses. Staff received training in safeguarding and made appropriate referrals. There was a range of psychological interventions available for patients as well as daily activities, which patients were encouraged to attend. Staff trained in British sign language (BSL) were available to patients on Fairbairn ward, which is the ward caring for people with impaired hearing. The provider had an induction programme for new staff and was supportive of further learning opportunities for all permanent staff. Staff received annual appraisals and most staff received regular supervision. Staff attended regular team meetings and recorded any actions and outcomes from these.

Are services caring?

Good

- Staff were passionate about their job and knew patients well. Patients told us staff worked hard and were kind to them. Staff treated patients with dignity and respect and were responsive to patients' individual needs.
- Patients had opportunity to raise any issues in community meetings. We saw evidence of these meeting minutes, and saw staff had taken the time to explain key points to patients. Patients had access to advocacy services. Patients were able to give feedback on the services they received.
- We observed a care planning meeting in which the approach was holistic, and allowed the patient to include their views, staff gave positive feedback to the patient during the meeting. In all wards, patients attended regular multidisciplinary team meetings where staff reviewed care and treatment.
- Staff worked with families where appropriate and updated them when anything changed.

However:

Summary of this inspection

- Several patients in forensic services told us bureau (St Andrew's bank) and agency staff were less caring and approachable.
- In the older adults service staff did not always maintain patients' privacy. On Cranford ward, staff had searched a patient in communal areas. This did not show consideration of patient privacy and dignity. In the adolescent service, we observed young people being searched upon return from leave in a corridor where others could see.
- Three out of six patients in PICU said staff did not always knock on the door prior to entering their bedroom.

Are services responsive?

Requires improvement

- Prior to admission staff from St Andrew's assessed the patient to ensure they were appropriate for the service. Patients were introduced to the ward on admission and where appropriate, a fellow patient acted as a "buddy" to support them settling in.
- All wards had a range of facilities to promote comfort and recovery. Patients had a choice of activities. There was a sensory room for each ward, which patients could use with staff as a quiet area. Wards had rooms for patients to meet visitors in private. Wards had telephone booths for patients to make telephone calls in private. Patients could make direct calls to access advocacy and complaints. Patients had lockable spaces in bedrooms to secure possessions.
- There was a range of psychological interventions available for patients. Staff designed all interventions to meet the needs of patients. Staff held activities daily and patients were encouraged to attend. Staff were trained in British sign language (BSL) on Fairbairn ward.
- There were small kitchens on some wards. Staff helped patients cook a meal to learn new skills. Patients said they could make their own breakfast in breakfast club.
- We saw patients' religious beliefs taken into account; staff said patients could attend the multi-faith room in the hospital. Food choices were available to meet dietary requirements of different religious and cultural needs.
- Patients knew how to complain and the provider investigated complaints. Staff supported patients with the complaints process, when needed.
- Staff provided patients with information in a range of different formats. This included easy read information and information in different languages for patients whose first language was not

English. Staff accessed interpreters and people who used sign language to help communication with individual patients. Information was available for patients in poster and leaflet form on rights, advocacy, complaint procedures and local events.
- There was a clear pathway through the services for patients who were ready to move on.
- The hospital had an education centre, workshops, cafeterias, gyms and swimming pools as well as the extensive grounds and outside ward space for patient use. Occupational therapists created personalised timetabled activity programmes. Patients could volunteer to apply for jobs within the hospital.

However:

- Patient views on the quality of the food were variable. Some patients on Cranford ward told us that the food was not of good quality and sometimes there was not sufficient quantity. However, a recent audit showed that patients rated food quality at 84%.
- In the forensic service, eight patients told us they had complained about lost personal property on the wards, five of these complaints were upheld.
- On Sherwood ward (PICU) the shower areas upstairs did not provide comfort, promote dignity or privacy.
- We observed that the managers' meeting minutes stated delayed discharge was an issue owing to the receiving service not having available beds.
- In the rehabilitation service there were no psychological interventions to address specific patient needs such as substance misuse.

Are services well-led?

Good

- There had been improvements since the last inspection. Leadership had been strengthened and new ways of working implemented to improve the patient experience. The provider had improved governance systems and carried out recruitment drives to attract staff.
- Staff we spoke with knew the provider's visions and values. Staff knew who the most senior managers in the organisation were. Nurse managers told us their senior managers and service directors were supportive.
- We saw leadership at ward level. Managers said they felt supported and staff said they felt valued. Senior staff monitored incidents and discussed outcomes in team meetings. Some senior staff gave examples of learning from incidents for their ward. Staff reported good morale amongst team members and

Summary of this inspection

told us their managers were supportive. Staff told us morale was increasing following a period of change over the last two years. Multidisciplinary teams worked well across all wards, for the benefit of patients.

- The provider managed quality and safety using a variety of tools. For example, there was a dashboard for monitoring ward performance, quality and safety against agreed targets. There was a monthly lessons learnt bulletin and red top e-mail alerts for all staff. Staff we spoke with were aware of their duties to be open and honest with patients when things went wrong. Systems were in place for reporting and recording incidents. Staff told us they knew the whistleblowing policy and felt that they could raise concerns. Managers were visible on the wards and staff felt supported by operational managers and clinical nurse leads.
- There were some robust governance processes. For example, there were both hospital wide and local audits. Staff completed annual satisfaction surveys to give feedback on the service and the provider had action plans for any improvements needed.

However:

- The provider did not have an effective management supervision structure. Supervision was highlighted as an issue in learning disabilities, older adults and rehabilitation services. Supervisions occurred monthly by peers rather than line managers. We saw that some staff had different supervisors each month. This meant there was no consistency and managers could not be sure that supervisors were addressing performance issues. Nurse managers were often managing more than one ward and told us they felt disconnected from patients.
- There was no local monitoring of training. Nurse managers relied on the provider's training department for prompts when training was due for their staff.
- Staff said very senior management were rarely seen on the wards in neuropsychiatry. Staff in rehabilitation services told us that recent changes to the organisational structure had taken place without staff input. Not all staff groups felt fully engaged with the service development programme.

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.

- Not all staff had completed training in the Mental Health Act (MHA) or the Mental Capacity Act (MCA). Staff did not receive annual MHA training and the provider could not demonstrate that all staff had received training in the revised MHA code of practice. This meant that staff might not be working to the most recent guidelines.
- Staff did not read patients their rights under section 132 of the Mental Health Act in some wards. If patients did not understand their rights, staff did not always make further attempts.
- Staff did not always upload the MHA legal detention papers in full to the electronic system.
- Consent to treatment forms were completed. However, records did not always reflect discussions which had taken place regarding capacity. Consultants did not always accurately complete medication consent paperwork (T2 and T3 forms). Care records in rehabilitation services were sometimes difficult to navigate and information was stored in different sections of the electronic system across the services. Staff kept some information in paper format.
- In some services staff did not assess patients' capacity to consent to treatment appropriately. Staff documented patients did not have capacity to consent but did not give a rationale as to why they had made this decision or document discussion held. Mental capacity assessments were not decision specific. Staff documented a list of decisions patients did not have capacity to make but they did not complete a capacity assessment for all of these decisions.
- Patients across the hospital could access the Independent Mental Health Advocacy (IMHA) service by pressing a speed dial number available on the patient phone. Patients we spoke with told us they had used this service and knew how to access it. Wards had posters detailing contact details and these were on display in the telephone rooms on wards. Staff made referrals on behalf of patients for IMHA support on admission and as needed. We observed IMHAs visiting patients on the wards. An independent advocate is specially trained to support people to understand their rights under the MHA and participate in decisions about their care and treatment.
- Staff had access to the MHA Administrators for administrative support and legal advice. Staff told us this was both efficient and effective.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider included training in the Mental Capacity Act (MCA) in their induction programme for all staff. Staff were expected to complete this training within one month of joining the service. The provider supplied data that showed 82% of staff had completed this training since June 2015. MCA refresher training is not included in the provider's mandatory training matrix. The provider could not be sure that all staff were aware of their responsibilities under the Act. The provider told us there are two courses planned for August and October 2016 in the MCA and Equality and Human Rights Act.
- Most staff we spoke with were able to explain their responsibilities under the MCA. Some patient records showed capacity assessments for significant decisions were completed and documented appropriately. Staff discussed capacity issues during multidisciplinary team meetings and documented these effectively. However, mental capacity assessments were not always decision specific. Staff listed decisions they felt the patient did not have capacity to make. However, staff did not complete capacity assessments for all of these decisions.
- Independent mental capacity advocates (IMCA) were available to support patients who lacked capacity. The provider had a policy on MCA, which included Deprivation of Liberty Safeguards (DoLS) information for staff reference.

Detailed findings from this inspection

- Staff we spoke with told us they were able to get advice on the application of the MCA when needed. Most staff told us they sought this support from the social workers and medical staff.
- In neuropsychiatry five patients were subject to Deprivation of Liberty Safeguards (DoLS). The provider had made five DoLS applications in the past six months all of which were authorised. Staff completed MCA assessments, to establish capacity to consent to care and treatment. The neuropsychiatric wards had six informal patients. Information on how to leave of their own free will was displayed on the doors of the wards.
- In the adolescent service, there was evidence of appropriate use and application of the MCA and best interest decisions on Bailey ward for one young person.

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	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Forensic inpatient/ secure wards	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Long stay/ rehabilitation mental health wards for working age adults	Good	Requires improvement	Good	Good	Good	Good
Child and adolescent mental health wards	Good	Requires improvement	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Requires improvement	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Services for people with acquired brain injury	Good	Good	Good	Good	Good	Good
Overall	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement

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

Requires improvement

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

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

Requires improvement

Safe and clean environment

- Some areas of the ward did not have clear lines of sight to observe patients. The provider mitigated where possible with mirrors and, at night, staff sat in the corridors to observe.
- We saw ligature points in all areas of the ward. A ligature point is an object to which a patient can attach an implement for the purpose of self-strangulation. There was a comprehensive ligature environmental assessment, which highlighted how each risk should be managed. The assessment, at times, stated 'managed by individual risk assessment'. However, the patient care plans did not reflect how staff managed the risk linked to the ligature risk assessment. The bedrooms had ligature points. Curtain rails were secured with screws rather than magnetic so were a potential ligature point also. Televisions in all bedrooms were not boxed in, with cables to the socket showing. This was a potential risk. Staff reported this was individually risk assessed but we were unable to find evidence of this in care records.
- The clinic room was clean, well stocked and maintained.
- We observed the ward environment was not clean. The upstairs bathroom was dirty. Some bedrooms had dirty carpets, smelled strongly of urine and ventilation was poor. The shower room curtains were dirty where they were in place.
- The upstairs bathroom had a plastic bin liner in the bin. This was in a patient area of minimal staff supervision. Patients could use this bag to self-harm.
- All staff wore personal alarms.
- There were no call bells in bedrooms, however at night staff sat in corridors near the bedrooms and could hear if a patient called out.
- Patients were not able to access their bedrooms freely during the day due to the rooms being located upstairs. Staff supported requests to access them if two staff were available; however, this would then affect staff availability downstairs for the remaining patients.
- Access to the garden area was restricted. Staff explained this was due to there being insufficient staff to support requests to access the garden and bedroom areas, rather than it being individual risk based assessment.
- There was space to receive visitors and there were special arrangements for children to visit off the unit. Staff said the patients would be risk assessed individually prior to a visit.

Safe staffing

- Between 1 March 2015 and 29 February 2016, data provided showed a sickness rate of 3%. Staff vacancies were 1% and three staff left in the last 12 months, with a staff turnover of 11%. The acting nurse manager advised that five posts had recently been recruited to and they were awaiting a start date.
- Use of bureau staff was consistent. Most vacant shifts were filled by staff who were familiar with the ward.
- Both staff and patients reported staff cancelled Section 17 leave at times due to staffing. Section 17 leave is where a patient is legally authorised to leave the ward under specific conditions written by a consultant psychiatrist.

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

Requires improvement

- The acting nurse manager was able to increase staffing according to patient need.
- Mandatory training compliance was 94.8% for the month of April 2016. The acting nurse manager was unable to provide information confirming what training this covered. The acting ward manager stated the information they had was not accurate. They said they relied on a monthly email from the learning and development team advising on staff training needs. However, a monthly email from the Learning & Development team (L&D) to all managers, including nurse managers, provided a link to the mandatory training performance reports. From these reports, managers were able to review which staff in their teams need to complete refresher training. The learning and development team proactively booked staff on to upcoming refresher courses to ensure that their training did not expire. Staff and nurse managers were made aware of these bookings via calendar meeting requests and emails so that they can organise rotas to accommodate the training. On a weekly basis, the L&D team provided each nurse manager with a list of their staff booked to upcoming training so that they can ensure staff attend and that training is recorded in ward rotas.
- Consultant provision had recently changed and the ward now had input from two consultants who split the caseload between them in addition to their responsibilities on other wards. Junior doctor provision was also available and staff said that responses were usually timely.
- Patients had reduced access to psychological services at the time of the inspection due to a staff member having left.
- The patients had access to a social worker, advocacy services and occupational therapists.

Assessing and managing risk to patients and staff

- There were two seclusion rooms on the ward. One was upstairs and one downstairs. Both met the minimum environment standards. However, the upstairs room also provided a shower room as part of the seclusion facility. In order for the patient to access it, staff had to unlock the seclusion room to enable the patient to enter the small shower room. This could pose a risk.
- Between 1 September 2015 and 29 February 2016, there were 34 incidents of seclusion and 41 incidents of restraint on 18 different patients. Eighteen of the 41 restraints resulted in prone restraint. Of these 18 occasions, 11 resulted in rapid tranquilisation.
- We checked six care records. Five out of the six patients had comprehensive risk assessments. A recently admitted patient did not have a full risk assessment on the electronic system. There was a risk assessment on paper from the transferring hospital. This was 48 hours after admission. The acting nurse manager confirmed there was no risk assessment documented.
- Two of the six records checked, did not have a plan on how to manage the identified risk in the care plan.
- Staff were trained in physical intervention techniques using Prevention and Management of Aggression and Violence (PMVA) training. Staff were booked onto the new MAPA (management of actual or potential aggression) training, aimed at training staff to use different techniques, encouraging physical intervention as a last resort.
- Safeguarding training was mandatory for all staff. Training figures submitted by the provider showed that 100% of ward staff had completed level 1 safeguarding, 100% level 2 and 82% level 3. Staff we interviewed were able to explain the safeguarding process.
- We reviewed 12 medicine cards. There was effective medicines management practice and all prescribing was carried out safely and administered correctly. However, there was a small quantity of an unknown substance recorded correctly in the controlled drug (CD) register which had been stored there since April 2016, rather than being disposed of. Controlled drugs were stored securely and recorded in the register.

Track record on safety

- Between 1 April 2015 and 31 March 2016 there were four serious incidents requiring investigation reported relating to allegations, or incidents of physical abuse and sexual abuse or abuse.
- In December 2015 there was a serious incident investigation into a patient admitted with incomplete detention paperwork**.**

Reporting incidents and learning from when things go wrong

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

Requires improvement

- Staff knew how to report incidents and we saw evidence of this on their reporting system.
- We reviewed the most recent serious incident, which happened in February 2016. The provider had completed the investigation and the acting nurse manager was reviewing the report for accuracy at the time of inspection.
- We checked team meeting minutes for February and March 2016, provided by the acting nurse manager. There was no mention of staff discussing the serious incident from February 2016, nor any immediate learning. There was no evidence of there being an immediate debrief.
- Staff reported they were able to review lessons learned across the service by reading information in a folder located in the ward office.
- There was evidence of discussion of serious incident learning at manager level meetings, which included the acting nurse manager and clinical nurse lead. There was no evidence of this being shared at ward level meetings, although staff said this could be discussed at the weekend meeting.

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 patient care records. Five out of the six reviewed had comprehensive and timely assessment completed after admission.
- Care plans were personalised and holistic. We saw evidence of patients' views documented and listened to in these records.
- Care plans were not all in one document, and the acting nurse manager told us that staff did not offer patients a copy of the additional care plan goals.

Best practice in treatment and care

- We reviewed 12 medication charts and found prescribing to be in accordance with National Institute for Health and Care Excellence (NICE) guidance and within the British National formulary (BNF) limits for safe prescribing.
- Staff used nationally recognised rating scales to assess and record patient severity and outcomes, which included health of the nation outcome scales (HoNOS).
- Care records showed that physical health examinations took place, however these assessments were not always comprehensive.
- Two of the records showed that after initial assessment, there was no reference to ongoing monitoring and action of physical health concerns.

Skilled staff to deliver care

- There was a multidisciplinary team of nurses, psychiatrists, consultants, occupational therapists, technical instructors, psychologists and pharmacy input.
- The acting nurse manager was also the substantive clinical nurse leader. There were also two consultants in the team who had joined the team in the last three months. Figures supplied by the provider show that supervision compliance was 100%. The acting nurse manager was not clear if the supervision was managerial and clinical or just clinical supervision.
- The team held meetings at the weekend on a monthly basis, led by the clinical nurse leads. Although there was a set agenda, it did not cover issues such as local incidents and lessons learned.

Multi-disciplinary and inter-agency team work

- There was a handover every morning to the multidisciplinary team, in addition to the handover between shifts.
- Staff worked with both internal and external agencies such as the Mental Health Act team, ministry of justice, police and local authority.

Adherence to the MHA and the MHA Code of Practice

- At the time of inspection there were 12 patients detained under the Mental Health Act 1983 receiving care and treatment.

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

Requires improvement

- The provider confirmed that 100% of new staff completed Mental Health Act training within one month of commencing in post. The provider advised it was a mandatory requirement for all new staff to complete this training.
- The provider did not provide evidence of Mental Health Act training as regular updates to existing staff.
- Consent to treatment forms were completed, however records did not always reflect discussions taken regarding capacity.
- None of the six records reviewed demonstrated discussion around capacity in the last three months.
- Patients were aware of their rights under Section132 of the MHA and staff recorded information in their clinical records.
- Staff did not upload the MHA legal detention papers in full to the electronic record. Some records had part of the paperwork uploaded. One set of paperwork had not been uploaded at all and the patient had been on the ward for over two months. This meant that staff were unable to access the information and therefore could not verify a patient's legal status via the patient's records. We confirmed that the Mental Health Act administration team did locate all the paperwork in their office and immediately uploaded the information onto the records.
- Consultants did not always accurately complete medication consent paperwork (T2 and T3 forms). One form did not cover all of the drugs initially prescribed and another was not updated when medication changed.
- We found some irregularity in dates on one set of paperwork.
- There was signage on the wards stating how patients can access independent mental health advocacy services (IMHA). Staff and patients were able to say how to do this.

Good practice in applying the MCA

- The provider did not supply individual ward information regarding the completion of Mental Capacity Act Training. Staff reported having received training in this area.
- Individual care records did not demonstrate detailed capacity assessments. The acting nurse manager was unable to find this information.
- There was no evidence in the care records of the multidisciplinary team meeting with the patient, or of any assessment of capacity.

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

Good

Kindness, dignity, respect and support

- We observed staff to be responsive, discreet and respectful at all times.
- We observed two multidisciplinary team (MDT) meetings and noted the team were compassionate, caring and listened to the patient.
- Staff communicated with patients in an easy, comfortable and professional manner, which demonstrated a caring and responsive relationship.
- Three out of six patients said staff did not always knock on the door prior to entering their bedroom.
- All six patients reported they felt respected and listened to.

The involvement of people in the care they receive

- We observed patients contributing to their care plans within the MDT meeting.
- Many care plans did not contain all information and so staff created additional care plans to document additional information. Staff said they did not routinely share the additional care plans with the patients.
- Patients did not always sign to say they had received or been offered a copy of their care plan.
- Patients had access to advocacy.
- There was a weekly community meeting for patients to express views regarding any concerns or ideas for the ward.

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

Requires improvement

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

Requires improvement

Access and discharge

- Staff responded to referrals in a timely manner.
- The average bed occupancy rate was 77%, which meant that patients needing a bed could be offered one.
- Staff reported that at times discharging was a problem due to the patient's local area citing no beds.
- We saw evidence of discharge planning within care plans.
- We observed that the manager's meeting minutes stated delayed discharge could be a problem at times. The problem was predominantly due to the patient's receiving service not having available beds.

The facilities promote recovery, comfort, dignity and confidentiality

- The shower areas upstairs did not provide comfort, promote dignity or privacy. There were two shower/ toilet areas upstairs, each with three to six shower cubicles. There was a shower curtain on some, but not all showers. The door to the room did not lock and patients needing the toilet had access. The bedrooms were not ensuite so this increased the potential for other patients to access whilst a patient was in the shower. The lack of shower curtain increased the lack of privacy.
- All bedrooms were upstairs and patients have restricted access to their rooms during the day.
- Patients had set times for drinks, but we did observe patients receiving drinks outside of these times on request.
- There was a variety of rooms and a garden area for patients to receive care, treatment and engage in activities. At the time of our visit the gym equipment was not working, except for one item. There was an activity timetable providing a range of activities seven days a week.
- There was a good sized outside garden. However, there was no seating to give patients a chance to relax. The nurse manager advised us that this was due to the fact that the seating was being cleaned and would be replaced thereafter.

Meeting the needs of all people who use the service

- Staff reported translated leaflets were available if required, but none was seen during the inspection. Patients were able to access interpreters.
- There was access to advocacy services.
- There were no set visiting hours as staff recognised that carers have to travel a distance to visit.
- Food choices were available which meet dietary requirements of different religious and cultural needs. However, patients had to choose from the menu two days in advance.

Listening to and learning from concerns and complaints

- The data provided, said that Sherwood ward received seven complaints between 2 February 2015 and 29 January 2016. Two of these complaints were upheld.
- Staff and patients confirmed they knew how to complain and felt able to if necessary.
- The ward management team discussed complaints on their agenda each month. However, it was not on the set agenda for the local ward meeting.

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

Good

Vision and values

- Staff we spoke with knew the provider's visions and values.
- Staff knew who the most senior managers in the organisation were and reported that senior managers were visible on wards.

Good governance

- Staff received mandatory training.

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

Requires improvement

- Staff received regular supervision and records showed almost 100% of staff received supervision and all staff received an annual appraisal.
- There were sufficiently trained staff on the ward and staff who knew the ward covered vacant shifts.
- Systems were in place for reporting and recording incidents. All staff were aware of the red top alert folder although it was not evidenced that all staff read it. There was a monthly lessons learned bulletin, which the provider distributed to all wards for staff to read.
- The manager was unable to access the provider risk register and could not explain the process.
- The provider managed quality and safety using a variety of tools. For example, there was a dashboard for monitoring ward performance, quality and safety against agreed targets.
- The acting nurse manager was not routinely sharing information from ward management meetings or clinical nurse leads with the wider team.

Leadership, morale and staff engagement

- Staff on the ward reported feeling supported and able to approach immediate ward management.
- The sickness rate for Sherwood ward was low at 3%.
- There had not been any reported cases of bullying or harassment in the last 12 months.
- Nursing staff told us they would feel supported to raise concerns without fear of victimisation.

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- Wards were spacious and had windows to view communal areas and lines of sight were good. Where there were blind spots, staff managed these with observation, individual patient risk assessments and mirrors where appropriate.
- Staff completed ligature risk assessments of the clinical areas. Wards contained very few ligature risks and staff managed known risks with observations and individual risk assessments. The provider installed yellow emergency boxes on the wards, containing ligature cutters and pocket masks (for use in mouth-to-mouth resuscitation).
- Bedrooms and bathrooms had anti-ligature fittings. However, on Seacole and Prichard wards, we found the ligature risk assessment had identified soap dispensers, paper towel holders and bath handrails as an ongoing high risk to patients. Staff had identified these risks in August and September 2015. The provider had not completed this work and the nurse managers had no dates for works to be completed.
- All forensic wards had seclusion rooms. Seclusion is defined as “the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others”. Seclusion rooms met required guidelines.
- However, we were concerned on Sunley and Prichard wards because the CCTV showed both the seclusion room and its toilet facilities. The screens were visible to any staff passing through the corridor and to staff in the nursing office. Patients using the low stimulus room, adjacent to the seclusion room, had free access to walk in the corridor. This meant patients would have sight of the CCTV monitors. This was a breach of the right to privacy and dignity for patients. The provider was not following guidelines contained in their operational policy for seclusion. Inspectors informed senior staff of these concerns whilst on site. Senior staff told us they would make changes to ensure the privacy and dignity of patients was protected.
- Wards had dedicated areas for de-escalation. We saw these were away from communal areas and allowed enough space for staff to care safely for patients. On Sunley and Prichard wards there was a dedicated corridor; which contained the seclusion room and low stimulus room. Patients had use of a soft, heavy chair in the low stimulus room on Sunley ward. However, there were no suitable chairs in this environment for staff to use, for example if staff were in seated holds with a patient, staff told us they would kneel on the floor. We were concerned that this would be difficult and uncomfortable for staff and patients.
- All areas of the ward were clean and in good decorative order. Furnishings were well maintained, comfortable and suitable for the environment. However, on Seacole ward, the furniture in the night lounge was dirty and damaged. Staff told us these were to be replaced. On Seacole ward staff told us the heating was not working efficiently. We found some areas of the ward to be very hot, while other areas were very cold, for example the sensory room. We found that a patient had complained about heating on Seacole ward in March 2015. The provider upheld this complaint. Two patients reported feeling cold to us. There were issues with controlling

temperatures on the ward. This was because of the air exchange system sending columns of cold air directly downwards when the ward gets above 28 degrees. The provider told us they were going to fit a safe diffuser over all of the ducts to try to diffuse the cool air over a larger area.

- Staff followed infection control protocol prior to administering medication. Staff had access to personal protective equipment, such as aprons and gloves in the clinical areas. Staff received mandatory training in infection control with only 1% and 2% of staff being out of date in the men's and women's services overall. Staff completed cleaning records. We viewed these and saw staff checked and cleaned clinical areas regularly.
- The provider maintained equipment on the wards. Electrical equipment was safety tested and stickers were used to show this. Staff completed environmental risk assessments daily and kept accurate records.
- Staff had personal alarms across all wards. Reception staff issued personal alarms to visitors to promote safety. Some bathrooms also had nurse call alarms for patient use in an emergency. However, these were not present in all bathrooms or toilets.

Safe staffing

- The provider used recognised tools to estimate the number and grade of nurses required to deliver safe care and treatment. The provider supplied data of their staffing establishment for this service. Across all nine wards, the total number of staff employed was 248. Wards had an average staff vacancy rate, across all disciplines, of 12%. The highest vacancy rate was on Spencer South ward at 35% and the lowest on Prichard ward at 3%.
- Wards had a total establishment of registered nurses of 85. The provider reported 28 vacancies for registered nurses. This represented a vacancy rate of 32% across the forensic inpatient secure wards. The provider had included the inability to recruit and retain qualified staff as an extreme risk on its risk register. The provider had an ongoing recruitment campaign to attract registered nurses. This had included running recruitment open days, relocation packages, and visiting universities to attract newly qualifying staff. Nurse managers across wards told us they had newly qualified staff due to commence work on their wards from September 2016. Wards had a total establishment of healthcare support workers of 158. The provider reported no vacancies for healthcare support workers.
- The provider used bureau and agency staff to fill vacant shifts across all wards. The data showed 4,705 vacant shifts were filled by bureau or agency staff between 1 December 2015 and 29 February 2016. The highest reported use of bureau or agency staff was on Stowe ward at 761. However, 1,414 shifts remained unfilled. This meant that the provider was unable to fill 30% of vacant shifts. Staff told us when shifts were not filled staff moved between wards to meet patient need, or wards worked short of staff.
- Senior staff told us staffing was low at night. The night co-ordinator covered all wards at William Wake House, Foster Ward and the psychiatric intensive care unit. This meant the night co-ordinator might not be available to support colleagues when needed. An incident had occurred on Prichard ward where low staffing had been identified as a contributing factor. The report stated that staff were unable to respond due to being involved in other incidents which depleted the staffing. Inconsistencies in practices between shifts was a "lesson learned".
- During the subsequent unannounced night inspection, staffing levels on Robinson ward were particularly poor. One member of staff was monitoring two people in seclusion. The provider's policy states that one to one observation is required and "The observing staff will not be allocated any other duties during their allocated span of observation". The provider was not, therefore, compliant with their seclusion policy. Senior staff on duty told us they felt one member of staff carrying out both observations felt safe as neither patient was a risk to themselves. However, the observing nurse had not been asked if they felt safe to monitor two patients at the same time.
- There was one registered nurse on some wards during the night. Senior staff told us that support was available from other wards employing two registered nurses, as needed. Staff told us that taking breaks on night shifts was difficult, as the registered nurses could not take their break away from the clinical environment. Healthcare assistants told us they were encouraged to take their breaks. On Robinson ward, they were encouraged to do this off the ward.

Requires improvement

Forensic inpatient/secure wards

- Staff and patients told us, and records confirmed that where possible, wards used regular bureau or agency staff to fill vacant shifts. This meant that temporary staff were familiar with the ward environments and had knowledge of the patient needs on the wards. Some regular staff told us they viewed the temporary staff as part of their teams. However, some staff raised concerns that temporary staff did not case manage. This put extra strain on the regular staff to complete essential paperwork.
- In one building the receptionist controlled access to three separate buildings from one reception area. Reception staff monitored the entry and exit of that building with closed circuit television (CCTV) monitors. Senior staff expressed concern that this caused unnecessary delays in patients re-entering the buildings following periods of leave, when reception staff were busy or away from their desk. Senior staff gave examples of when patients had waited outside buildings for access to the wards, causing distress to patients.
- Data was provided on staff turnover in a 12-month period from 1 March 2015 and 29 February 2016. Overall, the provider recorded an average of 14% substantive staff leavers. Spencer South ward had the highest turnover of staff at 25%. Fairbairn ward had the lowest at 3%. The provider advised us they were seeing an improvement in staff retention following the introduction of the 'your voice' campaign; designed to allow staff to express their concerns and feel more valued.
- The provider supplied data that showed staff sickness over a 12-month period. The highest reported level of sickness was Robinson ward at 4%. However, overall sickness was low across this service at 1%. Elgar and Sunley ward recorded 0% sickness over a 12-month period.
- Nurse managers confirmed they could request extra staffing to meet the needs of patients on their wards and felt supported to do this. We observed qualified staff were available to patients on the wards and responded to their needs in a timely manner. Patients reported that qualified staff were usually available to them when needed and spoke highly of nurse managers.
- Staff provided one to one time for patients to discuss their progress and needs, and we saw evidence of this in patient records. However, staff and patients told us that patients preferred to talk to regular staff, who knew them better than agency or bureau staff.
- Staff told us that patient leave was cancelled when staffing levels were low. However, when this occurred, staff made every effort to reschedule planned leave for patients. Twenty-four patients told us staff cancelled leave regularly due to poor staffing levels.
- The provider was changing the training on the prevention and management of violence and aggression to MAPA (management of actual or potential aggression). MAPA training focuses on the reduction of physical intervention and favours least restrictive practices. The Mental Health Act code of practice guidance supports physical interventions using least restrictive practice. The provider reported a process for delivering this training to all staff. Across the men's and women's services, the provider reported no staff overdue this training. The provider had a rolling programme of training staff in the new techniques and 16.7% of staff working in the women's service and 11.1% of staff in the men's service were due to undertake this training in the next month. Due to the above, the provider had a mixture of staff trained in differing methods of physical restraint. Staff expressed concern that different techniques were being used, which might result in confusion or injury to patients or staff. However, we observed staff using physical interventions on Prichard ward, following an incident and saw staff response was swift, efficient and respectful to the patients concerned. The provider supplied the training content for MAPA. Staff were taught emergency holding skills. The aim of this was to identify escalating behaviour and to use a range of strategies that prevented, decelerated and de-escalated aggressive behaviour in order to reduce the use of physical interventions. This supports staff to be able to make evidence-based decisions when using physical interventions as a last resort to manage aggressive and violent behaviour.
- Medical cover was available day and night. Wards had a consultant psychiatrist and an associate specialist. However, we saw that associate specialist doctors were covering two or three wards. Medical staff told us they were concerned that their workload was unreasonable.

- Staff completed mandatory training for a number of subjects, including equality, diversity and human rights, safeguarding, basic and immediate life support, management of actual or potential aggression (MAPA), collaborative risk assessment, electronic patient healthcare records, prevent awareness and manual handling. Data provided showed a variance in compliance with training across the men's and women's services. The highest reported compliance was MAPA training, with no staff overdue.
- Managers had access to dashboards for their teams, which gave details of staff compliance with mandatory training. Nurse managers reported they received prompts from the provider's training department when staff's mandatory training or refreshers were due. Most managers reported being reliant upon these prompts, because accessing the relevant information at ward level was difficult. However, a monthly email from the Learning & Development team (L&D) to all managers provided a link to the mandatory training performance reports. From these reports, managers were able to review which staff in their teams need to complete refresher training. The learning and development team proactively booked staff on to upcoming refresher courses to ensure that their training did not expire. Staff and nurse managers were made aware of these bookings via calendar meeting requests and emails so that they can organise rotas to accommodate the training. On a weekly basis, the L&D team provided each nurse manager with a list of their staff booked to upcoming training so that they can ensure staff attend and that training is recorded in ward rotas.

Assessing and managing risk to patients and staff

- Across all wards, there were 286 incidents in total, the highest being on Sunley ward at 92. The lowest incidents of seclusion were reported on Fairbairn ward at two.
- The provider supplied data on the number of incidents of long-term segregation over the six-month period from 1 September 2015 to 29 February 2016. Across all wards, there were 12 incidents of long-term segregation. The highest was on Sunley ward at four. Spencer South, Seacole and Fairbairn wards reported no incidents of long-term segregation.
- The provider had a policy to inform staff on the use and monitoring of seclusion and long-term segregation. We reviewed the seclusion records on all wards and found overall seclusion records were complete. Medical reviews took place in accordance with the Mental Health Act code of practice. However, we reviewed the clinical records for one patient on Sunley ward in long-term segregation. Staff had not recorded involvement by the commissioners, or that the safeguarding team had been informed, as required in the MHA code of practice. Staff did not always state the patient name or identifying number on seclusion records.
- The provider supplied data that showed there had been 830 incidents of restraint reported over the six-month period from 1 September 2015 to 29 February 2016. The highest incidents of restraint occurred on Sunley ward at 193 and the lowest on Fairbairn ward at three. Of these incidents 328 had resulted in patients being placed in the prone (face down) position. This meant that across the service, 39% of all restraints resulted use of the prone position. The highest percentage of prone restraints occurred on Sunley ward at 55%. Elgar Ward reported the lowest percentage of prone restraints at 6%. The Mental Health Act code of practice states that staff should not place patients in the prone position unless there are valid reasons for doing so.
- Staff used verbal de-escalation processes to manage agitated patients. We observed staff on Sunley ward caring for an agitated patient and saw they were compassionate and skilled in their interactions.
- Records showed low level prescribing and administration of rapid tranquilisation. Staff had administered rapid tranquilisation (RT) 221 times during restraint. This meant rapid tranquilisation occurred in 27% of all restraints.
- We reviewed the care and treatment records of 54 patients across all wards. Staff completed risk assessments on admission and updated these regularly. Staff discussed patients' risks with them during their ward reviews and updated their Positive Behavioural Support plans (PBS). Patients worked with staff to identify triggers to behavioural disturbance and actions to lessen risks. Patients told us they felt involved in this process and able to work better with staff to reduce incidents and manage behaviours.
- Staff ensured paper copies of PBS plans were available on all wards, for ease of reference, and uploaded PBS plans to the electronic patient records.
- Psychologists completed HCR20 risk assessments for patients and updated these regularly. HCR20 is a

comprehensive set of professional guidelines for the assessment and management of violence risk. Staff considered these assessments in the management of patients.

- The provider had a policy for the use of observations. Staff observed patients according to individual risk assessments and patient need. Staff reviewed patient observation levels regularly during ward rounds and multidisciplinary review meetings.
- All staff were required to complete mandatory training in safeguarding. The provider supplied data which showed 3% of staff across the men's and women's service were overdue level 1 and level 2 safeguarding training and 11% of staff across the men's service and 6% across the women's service were out of date with level 3 safeguarding. This meant that the provider had high levels of compliance across both services with safeguarding training.
- All staff we spoke with showed good understanding of their responsibilities to report safeguarding concerns and were able to give examples when this was needed. Staff made safeguarding referrals via the provider's incident reporting system. Social workers completed relevant referrals to the local authorities and informed the Care Quality Commission. Staff held safeguarding meetings to discuss management plans. We saw evidence of these meetings and associated action plans in patient records.
- We found blanket restrictions on some wards, for example on Sinclair ward, patients had access to their bedrooms at set times and on Seacole ward free access was limited to lower risk patients. Access to bedrooms was restricted during the day when activities, meals or medication was taking place and was not subject to individual risk assessment.
- There were effective processes for the storage, recording and administering of medication. Clinic rooms were clean and tidy. Emergency drugs were available and controlled drugs were appropriately stored and recorded in the register.
- We reviewed patient prescription cards. Medical staff prescribed medication in line with the National Institute for Health and Care Excellence (NICE) guidelines. Staff administered medication correctly and in accordance with guidelines and the provider's policy. The hospital had its own pharmacy on site. Staff were able to order required medications with minimal delay for treatment of patients.
- The provider had arrangements for children to visit. Children could not visit the ward environments, however across all wards there were dedicated rooms, away from the clinical areas where children could visit safely. On Spencer South ward, the visitors' room also had access to private outside space.

Track record on safety

- There were 42 serious incidents across the service between 1 April 2015 and 29 March 2016. The highest number was on Robinson ward. Staff reported no serious incidents on Spencer South ward.

Reporting incidents and learning from when things go wrong

- Staff told us, and records confirmed that all staff were familiar with the provider's incident reporting system. Staff were able to demonstrate the type of incidents they should report and received feedback from investigations, both inside and outside the service, via team meetings and emails. The provider issued 'red top alerts' to staff with information about adverse events and lessons learned.
- Staff investigated serious incidents and produced outcomes and action plans to address concerns. We reviewed the serious incident report for an incident on Prichard ward and found the report to be comprehensive. The provider identified that an extra 'floating' nurse was required on William Wake House to support qualified nurses on night shifts. Senior staff told us there were plans to fill this post with bureau staff until the provider could secure permanent staff. However, when inspectors returned for an unannounced night inspection there was no evidence of a "floating nurse" being introduced.
- On Spencer South ward, the provider changed the layout of the stairwell following a serious incident and on Stowe ward, the nurse manager had reduced the amount of keys staff that staff carried following delays in staff identifying the correct keys to medicine cupboards.
- Staff were aware of their responsibilities under duty of candour. This meant that staff were aware of their responsibilities to be open and honest when things had gone wrong for patients.
- Not all staff we spoke with told us they received a de-brief after serious incidents. However, staff reported that senior managers were supportive to the teams when incidents occurred.

Requires improvement

Forensic inpatient/secure wards

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We reviewed 54 care and treatment records for patients and found staff completed comprehensive assessments for patients as part of the initial referral process and on admission. Staff delivered care in line with individualised care plans.
- Staff completed and recorded physical health examinations and assessments on admission. We found evidence that staff monitored physical observations and physical health problems. Staff discussed physical health needs at multidisciplinary team meetings and physical health was considered in care plans. However, staff did not always complete physical healthcare monitoring following administration of rapid tranquilisation and seclusion records did not always indicate that physical health monitoring had been considered or documented. On Fairbairn ward physical observation charts were stored in the wrong folder and were incomplete. Staff did not always complete physical healthcare monitoring for patients prescribed high dose antipsychotic medication.
- On Stowe ward, we found one patient was prescribed clozapine (clozapine is an antipsychotic medication requiring specified physical healthcare monitoring). Staff recorded the patient had received a 'red alert' following routine blood testing, so withheld further administration of clozapine, in accordance with guidelines. However, staff had not recorded any physical observations and we found no evidence of follow up blood testing on the date requested by the pharmacist. Staff recorded a further 'red alert' some days later for this patient and withheld administration of clozapine but we found no evidence of physical health monitoring in care records. This was a potential risk to patient safety. However, the provider assured us the blood tests had been carried out but there was an issue that the blood results had not been entered into the electronic system.
- On Prichard ward staff did not regularly complete NEWS (National Early Warning Signs) physical observations charts. NEWS is a tool for tracking a patient's physical condition designed to alert the clinical team to any medical deterioration and triggering a timely clinical response. On Seacole ward, the NEWS charts were in place for the month of June. However, there were no escalation plans or increased physical observations for when the score had indicated this.
- Staff completed positive behavioural support plans (PBS) for patients. Care plans contained a range of needs and goals, were holistic and patient centred. Staff updated care plans following discussion with patients in their multidisciplinary review meetings. Patients identified their own triggers to behavioural disturbance and relapse and identified ways that staff could support them during periods of agitation. However, printed copies of PBS plans did not include a start date.
- The provider used an electronic patient records system to store patient information. All staff including agency had access to this system to record nursing entries and access patient information. We saw information for agency staff on how to access the database on the wards. Wards kept printed copies of patients' PBS plans for ease of access for staff.

Best practice in treatment and care

- Medical staff prescribed medication in accordance with National Institute for Health and Care Excellence (NICE) guidelines. We found minimum levels of polypharmacy across all wards. Polypharmacy is a term used to describe the prescribing of four or more medications to one patient. Patients are less likely to experience side effects from their prescribed medication when prescribed fewer medications.
- We saw a review of previous consent to treatment and capacity assessments showed reducing levels of medication prescribed for patients during their treatment. This indicated staff monitored patients' response to treatment and medical staff considered best practice when prescribing for patients.
- Patients had access to psychologists on the wards. Psychologists delivered a variety of therapies for patients, which included cognitive behavioural therapy, dialectical behavioural therapy and schema-focussed cognitive therapy. Psychologists offered patients both individual and group work. Patients reported finding psychological input useful.

Requires improvement

Forensic inpatient/secure wards

- The provider had a general practitioner (GP) and a team of physical health nurses on site. We saw evidence in patients' notes of referrals to specialists when required. Staff escorted patients who required emergency treatment to the accident and emergency department at the local acute hospital. A dietician was available when needed.
- Staff met the nutrition and hydration needs of patients across all wards. However, staff in forensic services did not always document fully what patients had been offered or received. There were gaps in records where staff had not signed the entries. Staff had documented in the patient's care record that adequate fluids had been given. Staff made entries detailing acceptance of food and fluids, however two records did not indicate the amount of fluid or type of diet the patient received. On Prichard, Seacole and Robinson wards, the seclusion records for three patients showed gaps between diet and fluid intake. Staff had not always recorded the volume of fluids patients had received. The provider's seclusion policy states "Details of food and fluid provided/consumed/refused will be recorded on the seclusion recording form". We were concerned that staff might not be offering or accurately recording when patients had access to diet and fluids consistently, or in accordance with policy.
- Staff completed recognised rating scales, such as health of the nation outcome scales (HoNOS), START (short-term assessment of risk and treatability), and discussed outcomes in multidisciplinary team meetings. Staff received mandatory training in HoNOS. The provider supplied data which showed that 57% of staff working in the men's service and 54% in the women's service were overdue this training. However, data showed that staff were booked to complete or refresh this training.
- The provider supplied details of clinical audits and dates for completion. Staff were allocated specific audits according to their roles. However, nurse managers told us that, at ward level, they allocated these tasks to team members when they were due. This meant that specific staff did not have overall responsibility for completing audits on a regular basis.

Skilled staff to deliver care

- Wards had a range of staff for care and treatment which included psychiatrists, nurses, psychologists, occupational therapists, technical instructors, pharmacists and social workers. The multidisciplinary team worked effectively to deliver safe care and treatment to patients.
- The provider supplied substantive and bureau staff with a corporate induction on joining the service. Dependent on job role, corporate induction was between one and five days, and included the mandatory training required for staff to be able to work safely and effectively. The provider consolidated the corporate induction by further e-learning covering areas like information governance, equality, diversity and human rights, and infection control. Staff were required to complete this e learning within one month of joining the service. Staff ensured agency and bureau staff received local induction to the wards to ensure they had good understanding of the needs of patients and the procedures of the wards.
- The provider ensured that newly qualified nursing staff received a six-month preceptorship programme to support them in their role.
- The provider enrolled all health care assistants and technical instructors onto a six-month "learning through work" programme that supported induction within the workplace and led to achievement of the national care certificate and a bespoke level four module accredited by the University of Northampton.
- Wards held regular team meetings and we saw minutes for these. Staff discussed patient needs, the environment, training issues and outcomes from complaints and incidents.
- Staff received regular supervision from their managers to address any performance issues or developmental and training needs. Nurse managers kept records of supervision for their staff on dashboards.
- The provider supplied data that showed 66% of non-medical staff had received an appraisal over the previous 12 months. The highest rate of appraisal was on Robinson ward at 78% and the lowest on Sinclair ward at 54%. These statistics were low; however, we considered that some staff might not be due an annual appraisal due to having recently joined the service.
- Staff could access extra training opportunities via the provider's intranet system. Staff told us they received support with accessing extra training when requested.

One staff member told us the provider supported them to complete a Master's degree. The provider told us that some unqualified staff had received training in dialectical behavioural therapy to assist psychologists.

- The provider told us they were offering an 'Aspire campaign', which supported healthcare support workers to undertake their nurse training. The provider would pay these staff a bursary to support their training, following which they would return to work at St Andrew's for a minimum of two years. The provider had plans to support 20 staff a year in this scheme.

Multi-disciplinary and inter-agency team work

- Wards held multidisciplinary team (MDT) meetings for patients every two to three weeks. Teams discussed the patients' current presentation and risk factors, updated care plans and risk assessments, planned for periods of leave, reviewed medication and discussed care pathways. Patients told us they felt involved in this process and they could access medical staff outside of these times, if needed. We attended a MDT meeting and observed this was effective in enabling staff to share information about patients and review their progress. Different professionals worked together effectively to assess and plan patients' care and treatment. Carers and family members were encouraged to attend, where appropriate.
- The MDT liaised with teams from outside the organisation, for example care co-ordinators and local authority social services, as needed. We saw examples in care records of effective communication between teams. Staff held multi-agency meetings to discuss specific concerns when needed.

Adherence to the MHA and the MHA Code of Practice

- The provider included training in the Mental Health Act (MHA) and MHA code of practice in their induction programme for all staff. Staff were required to complete this training within one month of joining the service. Data showed 91% of staff had completed this training since June 2015. Staff were expected to attend refresher courses which the provider delivered through their current "issues in mental health law" course, designed to cover significant changes to the code of practice. Courses were delivered as required and the provider told us they made staff aware that attendance was mandatory. However, the provider supplied no statistics to show staff compliance. We could not be sure that all staff were aware of the changes to the MHA code of practice or were sufficiently trained for their role. The provider told us a course on mental health law was provided in March 2015 and staff received training in receiving and scrutinising MHA section papers.
- Medical staff completed consent to treatment and capacity forms, either a T2 or T3 form. Staff attached copies to medication charts to ensure nurses administered in accordance with the MHA.
- Medical staff completed Section 62 (urgent treatment documentation) when making changes to prescribed medication not already authorised. We found the Section 62 form usually linked to a request for a second opinion appointed doctor (SOAD). However, on Seacole ward, one patient was receiving medication without legal authority following changes to prescribing. Staff had not completed Section 62 urgent treatment documentation. Another patient was receiving medication under T2 authorisation and medical staff had prescribed medication not included on the authorisation. One patient on Stowe ward had a Section 62 form for changes to prescribed medication; however, staff had not completed a referral to a SOAD for these changes. Staff should not administer medication to patients, detained under the MHA, without the legal authority to do so. The provider had medication audits in place to pick up such issues and has assured us the issue related to the section 62 has been addressed.
- Staff explained patients' legal status and rights under Section 132 of the MHA on admission, on renewal of detention and every six months as standard practice and we saw evidence of this in patient records. However, the electronic Section 132 form did not include the role of the Care Quality Commission in complaints about the MHA.
- Staff recorded patients' understanding, including their right to appeal their detention. The MHA administrators co-ordinated hearings and tribunals for patients and automatic hearings on renewal of detention.
- Staff completed MHA paperwork correctly and regular audits took place. The MHA administrators had a thorough scrutiny process.
- Staff stored original MHA paperwork securely in the MHA office and scanned documents into the electronic patient records for staff reference. However, we found some paperwork not scanned. This meant that staff on wards might not have access to these documents, when needed.

Requires improvement

Forensic inpatient/secure wards

- Staff had access to the MHA administrators for administrative support and legal advice. Staff told us this was both efficient and effective.
- Patients had access to independent mental health advocates (IMHA). Wards had posters showing contact details and these were displayed in the telephone rooms on wards. Patients could access IMHAs directly by telephone. Staff made referrals on behalf of patients for IMHA support on admission and as needed. We observed IMHAs visiting patients on the wards.

Good practice in applying the MCA

- The provider included training in the Mental Capacity Act 2005 (MCA) in their induction programme for all staff. Staff were expected to complete this training within one month of joining the service. Data showed 91% of staff had completed this training since June 2015. MCA refresher training is not included in the provider's mandatory training matrix. The provider could not be sure that all staff were aware of their responsibilities under the Act. The provider told us there are two courses planned for August and October this year in the MCA and Human Rights.
- Staff we spoke with were able to explain their responsibilities under the MCA. Patient records showed capacity assessments and best interest assessments for specific decisions were completed and documented appropriately. Staff discussed capacity issues during multidisciplinary team meetings and documented these effectively.
- Independent mental capacity advocates (IMCA) were available to support patients who lacked capacity, as needed.
- The provider had a policy on MCA, which included Deprivation of Liberty Safeguards (DoLS) for staff reference.
- Staff we spoke with told us they were able to get advice on the application of the MCA when needed. Most staff told us they sought this support from the social workers and medical staff.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- We spoke with 50 patients receiving care and treatment on the forensic inpatient/secure wards. We observed how staff cared for patients. Patients' views of how staff treated them varied. The majority of patients told us that regular staff were polite and respectful. However, several patients told us that some bureau and agency staff were less caring or approachable.
- Staff were responsive to patient needs, discreet and respectful. We observed good relationships between patients and staff on all wards. Most patients told us staff knocked before entering their rooms. However, two patients told us this did not always happen at night and they had put posters on their doors to remind staff to knock before entering. We observed staff speaking positively with patients.
- Staff were passionate and enthusiastic about providing care to patients with complex needs. They showed a good understanding of the needs of patients, for example, re-directing patients towards meaningful activity during periods of agitation, and distracting patients away from situations that were stressful to them.
- We saw staff working with patients to reduce their anxiety and behavioural disturbance, for example, managing patients in extra care rooms on high-level observations and playing board games with a patient who found mixing with other patients more challenging.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and we saw examples of actions taken to meet these needs. However, one patient on Seacole ward told us that agency staff often spoke with each other in different languages and this caused distress to patients.
- Eight patients told us they had lost personal property on the wards. The provider had upheld five complaints related to the management of patients' property between 2 February 2015 and 29 January 2016.

The involvement of people in the care they receive

- The provider completed assessments prior to admission and gave patients information about the service. Patients told us they were orientated to the ward on admission and staff allocated new patients 'buddies' to help them settle to the ward routines.
- Staff involved patients in writing and updating their positive behaviour support plans (PBS). Staff discussed,

evaluated and updated care plans with patients during multidisciplinary team (MDT) reviews. Staff recorded patient views in the PBS and patients signed and received copies.
- All patients spoken with knew how to access advocacy when needed.
- Staff and patients confirmed that families and carers could be involved in MDT meetings, if appropriate.
- Patients were able to give feedback on the service during their community meetings. We observed a community meeting and saw that staff involved patients throughout. Staff and patients recorded minutes of meetings for future reference.

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

Good

Access and discharge

- The provider supplied data related to average bed occupancy for the six-month period from September 2015 to February 2016. The average was 97%. The highest bed occupancy rate was on Fairbairn, which reported 101% and the lowest was on Stowe ward at 91%. This meant that wards were working at near or more than full capacity over this period. The recommended level is 85%.
- Senior staff attended weekly bed management meetings to discuss admissions and discharges. Staff who were unable to attend could dial into these meetings.
- Staff transferred patients between wards as part of their care pathway, for example to a higher or lower level of security.
- Between August 2015 and January 2016, the average number of delayed discharges across all services was 27. Senior staff on Fairbairn ward told us they had experienced delays in identifying suitable placements to meet their patients' specific needs.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had a range of rooms for care and treatment for patients. Some wards had larger bedrooms and toilets for patient use when being observed by staff. Patients had access to a swimming pool at William Wake House.
- On Stowe ward, staff cared for patients requiring extra support in a large extra care suite. Patients had a bedroom, lounge area, bathroom facilities and access to an outside courtyard with a protective soft floor area. The provider had carefully considered the needs and safety of patients using this area.
- All patient bedrooms had ensuite facilities. Some patients had keys to their bedrooms, subject to individual risk assessments.
- Patients had access to private rooms in which to meet visitors. Patients could also meet visitors in the café in the grounds, subject to risk assessment and leave arrangements.
- Wards had telephone booths for patients to make telephone calls in private. Patients could make direct calls for access to advocacy and complaints. Patients purchased telephone cards to make calls.
- Patient views on the quality of the food were variable. The provider had received a Food Standards Agency maximum rating of five, for food hygiene in all food preparation areas.
- Patients had access to hot drinks and snacks at specified times, which staff told us was for safety reasons. We saw that staff offered patients hot drinks multiple times during the day and at meal times and fruit juice and fruit was always available. On Spencer South ward, patients had access to the visitors' room to make hot drinks, subject to individual risk assessment.
- Patients were able to personalise their bedrooms. We saw artwork, personal photographs and possessions in patient bedrooms. Occupational therapists assisted patients to personalise ward environments. We saw murals and paintings, completed by patients.
- Patients were able to secure their possessions. On some wards, patients had lockable cupboards, which were accessible at patient request. Staff advised that patients do not hold their own key due to some contraband items, such as hair straighteners, being stored in these spaces. Staff accessed requested items for patients in accordance with individual patient risk assessments.

Requires improvement

Forensic inpatient/secure wards

- Occupational therapy staff and psychologists organised a range of activities for patients. Staff placed activity timetables in the clinical areas and patients held their own copies. Staff organised activities for patients at weekends.
- Patients had access to work placements, such as working with the health and safety team, caretaking and light and heavy industry. The provider had a gym and sports hall, a café, swimming pool, arts and crafts room and a recording studio. Patients could participate in horticulture on the wards.
- Patients told us they enjoyed the activities available and found them useful to their recovery. However, 24 patients told us that staff cancelled activities when staffing was low.

Meeting the needs of all people who use the service

- We saw disabled facilities on some wards. For example, on Spencer South ward, a lift was available and one bedroom provided extra space for a disabled patient. The ensuite was appropriately equipped and spacious. On Fairbairn ward patients with hearing difficulties had access to vibrating alarm clocks.
- The provider supplied leaflets in other languages for patient use, as needed. Staff had access to patients' rights leaflets in different languages and in 'easy read' format.
- Wards had information on patient rights, advocacy and how to complain. Wards had posters located in the telephone rooms for patient use. Information on treatments, local services and activity programmes were visible in the ward areas on some wards. On other wards, staff told us they kept information in folders as patients often removed posters. On Fairbairn ward, posters included pictorial messages in British sign language (BSL).
- Staff had access to interpreters from inside and outside the service. On Fairbairn ward, staff were employed who had training in British sign language (BSL) and two interpreters were available on every shift to assist staff to communicate effectively with patients with hearing difficulties. However, staff told us they needed more interpreters.
- Patients could select from menus on a daily basis. The provider offered a choice of food to meet dietary requirements of religious and ethnic groups.
- Staff told us patients' spiritual needs were assessed on admission and information was included in care plans. The provider had a chaplaincy service and offered spiritual support for a variety of faiths and denominations.

Listening to and learning from concerns and complaints

- There had been 127 complaints in the last 12 months. The provider investigated complaints and upheld 28. The highest number of complaints were for Robinson ward at 36, of which 4 were upheld, for example cancellation of activities due to inadequate staffing, delay in patient accessing medical records following request, loss of patient property, and delays in receipt of post.
- Staff we spoke with knew how to handle complaints appropriately and nurse managers reported the outcome of complaints during team meetings. Patients received feedback from progress and outcomes of complaints from staff. Independent Mental Health Advocates (IMHA) and staff supported patients during the complaints process when needed.
- The provider reported no complaints had been referred to the Independent Sector Complaints Adjudication Service (ISCAS).
- All patients spoken with knew how to make a complaint. Staff placed information posters on wards and in telephone rooms.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- Staff we spoke with knew the provider's visions and values.
- Staff knew who the most senior managers in the organisation were and reported that senior managers were visible on wards. Nurse managers reported their senior managers and service directors were supportive and visible on their wards. However, they rarely had contact with managers above the level of service director.

Good governance

Requires improvement

Forensic inpatient/secure wards

- Nurse managers told us their roles had become operational and not clinical. They told us they felt disconnected with the patients on their respective wards as a result. Nurse managers were often managing more than one ward and as a result, told us they were unable to offer as much support to staff as they would like. Clinical nurse leaders told us they felt supported by their managers, however did not have as much contact with them as they needed. For example, one clinical nurse leader told us they only saw their manager three or four times each month.
- Senior staff used dashboards to monitor staff compliance with mandatory training. From these reports, nurse managers (and other managers) were able to review which staff in their teams need to complete refresher training.
- Senior staff held records of staff supervisions and appraisals.
- Senior staff told us they had continued difficulties in covering shifts with sufficient numbers of staff. Some managers told us that their staff were often re-deployed to other wards when staffing levels were low. They told us this could disrupt care for patients and affected patients' access to leave arrangements.
- Nurse managers involved their staff in clinical audits on request.
- Senior staff monitored incidents via their incident reporting system. Staff investigated incidents and outcomes and actions were discussed with staff during team meetings.
- Senior staff gave examples of learning from incidents, complaints and service user feedback.
- Nurse managers told us they had sufficient authority to manage their wards and senior managers supported them in their role.

Leadership, morale and staff engagement

- Staff knew how to use the whistle-blowing process and told us they could raise concerns.
- Staff reported good morale amongst team members. However, some staff expressed concerns about staffing levels.
- Multidisciplinary teams worked well across all wards, for the benefit of patients.
- Senior staff told us their teams were aware of their responsibilities to be open and honest with patients when things went wrong.
- Staff attended regular team meetings and were able to give feedback on services. We saw minutes of these meetings.

Commitment to quality improvement and innovation

- The provider submitted the final report of the accreditation for inpatient mental health services (AIMS) for the visit carried out in March 2015 on the women's medium secure unit. The provider was 100% compliant with security, safeguarding and governance. The report found the service had not fully met the standard for friends and family test or patient pathways and outcomes. The provider had an action plan in place.

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

- Ligature points (a place where someone may tie something in order to harm themselves) were identified on the wards. Managers had identified the points within a ligature risk assessment, which included assessing the risk to patients and identifying ways in which the risk to patients could be reduced. This included observing patients in areas where risks were present.
- The wards were rehabilitation wards and patients were established in their mental health treatment. There were no recent incidents of self-harm by ligature on Thornton or Ferguson ward. Spring Hill house had different areas within the ward that patients lived in depending on risk. Staff managed patients that were high risk in area 'A' which did not have any visible ligature points.
- There were no mixed sex wards in the rehabilitation services.
- Staff kept clinic rooms in good order. Rooms were tidy, organised and well maintained. Staff monitored fridge temperatures appropriately and completed weekly checks on equipment. Staff did not have access to an appropriate treatment room on Ferguson ward. One room contained an examination couch and scales but was small, untidy and disorganised. The provider was completing renovation work at the time of inspection and had recently installed a wipeable floor to comply with infection control guidelines.
- Wards were visibly clean and well maintained. The provider employed staff to clean the ward environments. Staff cleaned the wards regularly and kept records to reflect this. Staff ensured cleaning cupboards were in order and they locked chemicals away.
- Staff used personal alarms to summon help if required and patients had access to call bells in their room if they needed assistance from staff.

Safe staffing

- Staff were present on wards at all times and observed patients to ensure they were safe.
- The provider employed a total of 66 whole time equivalent (WTE) staff across the rehabilitation services. This included nurses and healthcare assistants. Staffing establishment for Thornton was 13 WTE nurses and 17 WTE healthcare assistants. Ferguson establishment was 11 WTE nurses and 15 healthcare assistants. Spring Hill House staffing establishment was 12 WTE nurses and 18 healthcare assistants. There were two nurse vacancies for Thornton, two healthcare assistant vacancies for Ferguson and Spring Hill House had eight healthcare assistant vacancies. Between 1 December 2015 and 29 February 2016, rehabilitation services used bureau staff to provide cover for 1269 shifts. The bureau was an internal bureau of staff used by St Andrew's Northampton. The provider was unable to fill 273 (22%) shifts with bureau or agency staff in the same period.
- Between 1 March 2015 and 29 February 2016, Thornton ward reported a sickness rate of 1%, Ferguson reported 3% and Spring Hill reported 1%. For the same period,

Long stay/rehabilitation mental health wards for working age adults

Good

Thornton ward staff turnover was 26% as eight staff left their post in the last 12 months, Ferguson turnover was 11% as three staff left post and Spring Hill House turnover was 30% as nine staff left.

- Managers determined the staffing levels for wards with the senior managers at the hospital. They considered needs of the patients on the wards and financial costs.
- In the last month, two shifts across rehabilitation services were not staffed to the established level and were not filled by bureau staff. Both shifts were one nurse short.
- Managers arranged to cover shifts through the St Andrew's healthcare bureau, their equivalent of bureau staff. Regular bureau staff were used where possible to provide consistency for patients.
- Ward managers had sufficient authority to organise the use of bureau staff. The daily bleep holder, if required also moved staff to different wards.
- Staff scheduled weekly one to one sessions with patients and recorded the sessions in the care records. Patients told us that staff cancelled activities if the ward was short staffed. Managers explained that this would only happen if the staff absence was unexpected and short notice. Managers planned staffing levels to ensure there were enough staff to carry out physical interventions if required.
- Doctors provided on call support to teams over a 24-hour period via an on call rota.
- Mandatory compliance was 92% for Ferguson, Thornton was 88% and Spring Hill House was 98%. The provider included equality and diversity, basic life support, immediate life support, management of actual and potential aggression and self-harm and suicide training as part of the mandatory training programme.

Assessing and managing risk to patients and staff

- From 1 September 2015 to 29 February 2016 staff reported two episodes of seclusion on Ferguson ward. However, the seclusion log on the ward showed one episode recorded for this time. For the same period, staff reported two episodes of seclusion on Thornton and six episodes on Spring Hill.
- There were no incidents of long-term segregation across all three wards.
- From 1 September 2015 to 29 February 2016 staff reported three incidents of restraint on Ferguson ward. Incidents related to three patients. Of the three incidents, one resulted in a patient being restrained in prone position (face down) and rapid tranquilisation did not follow. Staff reported four incidents of restraint Thornton ward that related to one patient. Two of the incidents resulted in the patient being restrained in prone position and both examples resulted in rapid tranquilisation being administered. Staff reported 16 incidents of restraint on Spring Hill House. Incidents related to three patients. One incident resulted in a patient being restrained in the prone position and rapid tranquilisation was not administered.
- Staff assessed patient risk on admission to the hospital and updated risk assessments following incidents or when patients' needs changed.
- Staff used START (short-term assessment of risk and suitability) to assess patients risks on admission. Staff updated risk assessments when a patient's situation changed to ensure information was up to date and accurate.
- Staff restricted patients smoking times to one per hour on all wards. This was to encourage patients to engage with structured activities and to support patients in reducing smoking. The provider was planning to start 'smoke free' premises in July 2016.
- Patients were detained under the Mental Health Act (MHA). There were no informal patients at the time of inspection. Staff observed patients in line with the provider's policy. Members of the multidisciplinary team decided patients observation levels based on risk and staff recorded observations on observation logs. Staff searched patients on return from Section 17 leave to ensure that contraband was not brought on to the ward.
- Staff used de-escalation first to support patients. Staff used restraint when de-escalation failed.
- Staff recorded rapid tranquilisation correctly and monitored patients physical health appropriately following the administration of this.
- A total of 95% of staff had received training in safeguarding vulnerable adults. The provider included three levels of safeguarding as part of the mandatory training programme. Data showed 97% of staff were trained in level one safeguarding, 97% were trained in level two and 92% were trained in level three. Staff accessed support and advice from the allocated ward social worker to discuss safeguarding incidents and to make appropriate referrals to local authorities. Staff described the different types of potential abuse and were aware of the safeguarding policy.

Long stay/rehabilitation mental health wards for working age adults

Good

- Staff managed medicines effectively and in line with good practice. The services had organised and well stocked clinic rooms. Pharmacists visited the wards weekly to complete medication audits. Managers received the audit reports and took action on any issues raised. Medication checks were completed and there were no discrepancies.

Track record on safety

- Between 1 April 2015 and 29 March 2016, staff reported ten serious incidents that required investigation. Two related to Spring Hill House and six related to Thornton ward. Two related to Ferguson. The Spring Hill House incidents related to patient absconsion and concerns raised by a family member. Thornton incidents related to patient absconsion and the use of illicit substances.

Reporting incidents and learning from when things go wrong

- Staff knew what situations required reporting as an incident. Staff described the process for incident reporting from the initial notification to feedback received in team meetings.
- Staff reported incidents using an electronic system. Managers received notifications that staff had reported an incident and completed an initial review of the information.
- Managers investigated incidents and closed the record on the electronic system once satisfied that staff had taken appropriate action. Managers used team meetings to feedback lessons learnt to staff.
- Managers supported staff following serious incidents by offering debriefs. Managers were in regular contact with staff that had been involved in recent incidents and were offering appropriate support.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We reviewed 25 care records during the course of the inspection.
- Doctors completed comprehensive assessments prior to and after a patient's admission. This included seeking information from other professionals prior to the patient beginning treatment at St Andrew's Northampton.
- Doctors and staff completed physical assessments on admission. However, staff did not always respond appropriately to physical healthcare needs of patients. One example showed a delayed response for a patient whose oxygen saturation was 69%. Staff had not completed any physical observation paperwork to assess the potential harm to a patient with 69% oxygen saturation. Staff recorded an entry on the electronic notes that the oxygen saturation was measured at 20:30 and the patient was experiencing confusion and was struggling to respond to staff. Staff also recorded the patient fell into a deep sleep and could not be woken. Staff recorded that the duty doctor attended at 23:15 and the duty bleep holder came to the ward at 21:50. Staff recorded an entry at 23:52 reporting the patient was in a deep sleep and unable to wake up. Staff recorded oxygen saturation at 80% and recorded the patient's potential condition was not clear, and should be reviewed by the doctor the following morning.
- Staff completed personalised, holistic care plans with patients. This included ways to manage patients when they were feeling unwell. Staff regularly updated care plans.
- Staff across the wards stored patient documentation on different parts of the electronic records. This meant the records were difficult to navigate and information was not always easy to find. Staff recorded patient positive behaviour plans on paper that were kept in files on the ward providing easy access to this information for all permanent and bureau staff.

Best practice in treatment and care

- Doctors prescribed medication in line with National Institute for Health and Care excellence (NICE) guidance. If patients were prescribed high doses of medication, doctors completed additional care plans to ensure staff were aware of risks and the monitoring required.
- Psychologists provided individual therapy to patients on all wards to support treatment and care.
- Staff supported patients to access specialised health care as and when required. This included access to dentists, podiatrists and opticians.
- Staff mostly monitored and recorded patient food and fluid intake where appropriate. However, one example

showed a patient had potentially not eaten or drank for four days until this was recorded as an issue by staff. Action was then taken. The remaining records inspected showed that staff recorded food and fluid intake for patients, particularly where previous issues had been identified with patients restricting their food.
- Staff completed weekly audits of the clinic room to ensure medication stock was correct and the room was clean and tidy. Pharmacy staff completed weekly audits of medication administration records. The provider completed a variety of clinical audits across the service. Responsible clinicians completed a care plan audit in November 2015 and the clinical audit team completed an audit of Section 17 leave in January 2016.

Skilled staff to deliver care

- The multidisciplinary team (MDT) consisted of psychiatrists, nurses, psychologists and occupational therapists. The MDT provided patients with access to a variety of roles and experience to support their care and treatment.
- Staff received a structured induction when they started in their role that provided them with initial training and opportunities to learn about the provider.
- Staff received clinical supervision on a monthly basis from a supervisor that did not work on their regular ward. Managers provided management supervision as and when required by staff. The service was meeting clinical supervision targets across all wards.
- The provider had focused on improving the appraisal rate, which resulted in higher completion rates and improved quality of the appraisal process in general. Appraisal compliance rates for 2016 were Ferguson at 100%, Thornton at 81% and Spring Hill at 100%.
- Staff accessed specialised training once approved by ward managers. Managers would seek financial approval from the provider if the training request would benefit the patients on the ward.
- Managers addressed poor staff performance through management supervision. Managers would meet with staff in a one to one appointment, once they were aware of concerns, to discuss this with staff and create actions to address the issue. This could mean supervision was seen as punitive rather than supportive and developmental.

Multi-disciplinary and inter-agency team work

- The multidisciplinary team met on a weekly basis to review patients' progress and to address any issues with patients care and treatment.
- Staff met at the beginning and end of shifts to handover information regarding patient care. This included information about risk and how patients had interacted during the shift.
- Staff communicated with other teams when necessary. An example recorded in notes showed communication between wards when two patients had negative interactions when attending their work placement.
- Staff recorded communication with outside agencies. This included local authority teams and social services.

Adherence to the MHA and the MHA Code of Practice

- Overall, 82% of staff received training in the Mental Health Act (MHA) since June 2015. This took place during the staff induction. The provider did not provide any training figures for staff that started employment prior to June 2015 to demonstrate staff received regular MHA training. Staff received training and information on the revised code of practice during their induction and demonstrated a good understanding of the MHA.
- Staff recorded consent to treatment in the patient records and attached original documents to the medication charts appropriately.
- Staff read rights to patients on a six monthly basis. It was unclear, when a patient refused their rights, whether staff revisited this.
- Staff supported patients to access Section 17 leave appropriately. Patients could access leave on the grounds or in the community dependant on risk. Responsible clinicians authorised Section 17 leave six months in advance and recorded conditions clearly. Staff assessed patient risk prior to leave and recorded how patients were feeling on return. Patients accessed work placements and education whilst on leave, where appropriate, to support their rehabilitation.
- Mental Health Act administrators scrutinised paperwork using a comprehensive checklist designed to highlight any errors and omissions. Section paperwork was completed appropriately on the ten MHA records inspected. Staff uploaded MHA paperwork onto electronic patient records. However, not all documents were found on the electronic records but were located in the MHA office where documentation was organised and stored securely.

Long stay/rehabilitation mental health wards for working age adults

Good

- Managers completed an MHA audit on Ferguson ward in October 2015, Thornton ward in October 2015 and Spring Hill House in February 2015. Results of the audits were not provided.
- The service displayed independent mental health advocacy (IMHA) information across all wards. This included the role of the IMHA and contact details.

Good practice in applying the MCA

- Overall, 82% of staff received training in the Mental Capacity Act (MCA) since June 2015. This took place during the staff induction. The provider did not provide any training figures for staff that started employment prior to June 2015 to demonstrate staff received MCA training.
- No Deprivation of Liberty Safeguards (DoLS) applications had been made in the previous six months.
- Staff knowledge of mental capacity varied across the teams. Staff who had undergone training recently were able to describe the principles of the MCA effectively but this was not consistent and some staff were unable to describe how capacity should be assessed on a decision specific basis.
- For patients on Thornton and Ferguson wards, notes indicated that patients had full capacity so assessments were not appropriate.
- Staff sought advice from responsible clinicians and clinical nurse leads if they required information about MCA and DoLS.

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

Good

Kindness, dignity, respect and support

- Staff interacted with patients in a respectful way and provided appropriate practical and emotional support.
- Patients said they felt staff cared about them and would help them when they needed it.
- Staff knew individual patient's needs and explained ways they would support patients to meet their needs.

The involvement of people in the care they receive

- Staff spent time with patients on admission to the ward to introduce them to other patients and familiarise them with the environment.
- Staff included patients in the care planning process. Staff gave patients copies of their care plans and patients told us about the goals they were working towards. Staff recorded patient goals in their own words. Patients attended multidisciplinary team (MDT) meetings and provided updates on their progress.
- Staff displayed information on wards explaining how patients could access advocacy services.
- The service involved families and carers where appropriate and with patient's permission. Staff recorded telephone contact with families on the patient's records and provided updates when there were changes to a patient's care and treatment.
- Patients attended weekly community meetings on all wards. The agenda gave patients the opportunity to provide feedback on the service and any improvements they wanted to make. Patient representatives from each ward attended patient forums with other patient representatives from other services. This was an opportunity for patients to discuss issues about St Andrew's Northampton as an entire hospital.
- This service did not involve patients in recruiting staff.
- Staff supported patients to make advanced decisions about their care. Staff ensured they revisited this with patients if they initially refused to complete one.

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

Good

Access and discharge

- Between 1 September 2015 and 11 February 2016 bed occupancy for Ferguson ward was 95%, Spring Hill House was 105% and Thornton ward was 64%. St Andrew's Healthcare Northampton admitted patients from anywhere in the United Kingdom.
- Patients returned to their own bedrooms on return from Section 17 leave.

Long stay/rehabilitation mental health wards for working age adults

Good

- Staff planned discharges, where possible, to ensure the patient was supported appropriately. These included introducing patients to staff who would support them in community placements.
- Staff transferred patients to other wards within the service if they required increased support.
- Patients experienced delayed discharges whilst waiting for community placements. The provider reported 166 delayed discharges between 1 August 2015 and 31 January 2016 across all services. In long stay services there were four delayed discharges of patients. Staff and managers told us that any delays in discharge occurred whilst waiting for appropriate community placements.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had access to a variety of room and equipment to engage in activities to support their care and treatment. Patients could use a variety of rooms on all wards to meet visitors that were quiet and private. Patients could make telephone calls in private on all wards.
- Staff supported patients to access outside space and all wards had courtyards.
- Patients said they enjoyed the food and had a wide variety of choice. Patients on all wards had access to hot drink from tea trolleys. Patients were able to purchase snacks and they were stored for them to access at any time.
- Patients were able to personalise their bedrooms, this included the deciding the colour of the walls. Patients had access to lockable cupboards in their bedrooms to store personal possessions. Patients had keys to their rooms.
- Staff provided activities for patients to take part in throughout the week and at evenings and weekends. Staff prioritised therapy sessions during the week with social activities as the focus during evenings and weekends. This was to prepare patients for living in the community if they secured employment.

Meeting the needs of all people who use the service

- Staff assessed any physical impairment a patient may have to ensure suitable accommodation was provided. All wards provided accommodation for patients requiring a wheelchair.
- Psychology staff did not provide structured support for patients with identified substance misuse problems. Some patients who failed to return from leave were using illicit drugs and managers told us that they were able to access support for this. Staff did not record substance misuse specific interventions in the case notes.
- The service displayed information in English across all wards. Staff were able to request information in other languages from the provider, if required. Staff could access interpretation services if required.
- The service displayed information about independent mental health advocacy, positive behaviour support, safeguarding and chaplaincy. Staff displayed posters on all wards about how to speak with a CQC inspector, the patients' recovery forum and how to make a complaint.
- Patients bought and prepared their food once risk assessed as safe to do so. Apart from the example detailed above, the provider ensured that dietary requirements were met appropriately for those who did not self-cater.
- The provider employed chaplaincy staff who were available to support patients with their spiritual needs. Patients could visit a church within the grounds and were supported by staff to access other places of worship in the community.

Listening to and learning from concerns and complaints

- From 2 February 2015 to 29 January 2016, the service received eight complaints, three of which were upheld. The complaints related to staffing and patient care.
- The service did not refer any complaints to the Independent Sector Complaints Adjudication Service (ISCAS) during this time.
- Patients knew how to complain and told us information was displayed on the ward about how to do this. Patients also said they were able to raise concerns in ward rounds. Staff recorded this in patient notes.
- Staff described how to record and escalate complaints appropriately.
- Managers discussed complaint outcomes with staff in team meetings to share learning.

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

Long stay/rehabilitation mental health wards for working age adults

Good

Good

Vision and values

- Staff described the provider's values and how they applied to their work with patients.
- Staff were aware of the senior managers in the organisation and gave examples of modern matrons visiting the service. Staff were unable to recall the last time members of the board visited the service.

Good governance

- The training team recorded and monitored training compliance and provided operational managers with alerts when staff required training. Managers did not have immediate access to this information to check overall training compliance for their wards.
- Managers monitored clinical supervision compliance and all wards were achieving 100% compliance. Managers did not meet with staff regularly to discuss operational issues in management supervision and would address performance issues as and when they were brought to their attention. Managers were completing annual staff appraisals.
- Managers staffed wards to appropriate levels to meet patient needs. Managers had sufficient authority to increase staffing numbers as and when required.
- Staff recorded regular one to one time with patients as outlined by care plans. Staff time with patients was prioritised over administration tasks.
- Staff recorded incidents appropriately and managers completed appropriate investigations and shared learning across the team once complete.
- Managers reported monthly performance on a dashboard, which they discussed at senior management meetings. Managers provided comments to explain any deficit in performance. Dashboards flagged any area of concern for managers to address promptly.

Leadership, morale and staff engagement

- Staff participated in a staff survey between 19 October 2015 and 6 November 2015. A total of 49% of staff responded to the survey and the provider identified four areas which were required to improve staff engagement. This included 'I can make a difference', 'reward and recognition', 'I feel part of St Andrew's and my opinion matters' and 'I have the environment and tools to do my job. Managers created action plans to address the results of the survey and the executive board were receiving monthly updates on progress.
- Staff were not absent from work on a regular basis. Sickness levels were below 5% across all wards.
- Staff had not submitted any recent cases of bullying and harassment.
- Staff described how they would raise a complaint using the whistle blowing process and did not report any concerns regarding victimisation if they raised an issue.
- Staff reported feeling positive about their roles and supported in their work. All staff commented on recent changes to the organisational structure and staff felt that the executive team could have managed the consultation in a more positive way. Staff felt that the restructure was decided prior to the changes and there were limited options to comment.
- Staff had the opportunity to develop in their roles with specialised training. Managers in the service were introducing a lead rehabilitation healthcare assistant to support the development of the service.
- Staff supported patients to raise issues and explained the outcome of investigations to patients.

Commitment to quality improvement and innovation

- The provider had a quality improvement strategy in place to adopt following various public inquiries. The strategy included improvements to be made by 2020.
- The provider was not engaged with any quality improvement programmes in this service at the time of inspection.

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Safe and clean environment

- Some wards had blind spots where staff could not observe patients at all times. However, the staff mitigated this risk by having restricted access to such areas, having staff positioned in blind spot areas to ensure clear visibility or by using enhanced patient observations.
- Each ward had an up-to-date ligature risk assessment, which identified possible ligature points. A ligature is a fixed item to which a person could tie something for the purpose of self-strangulation. Staff managed risks identified with enhanced patient observations, restricting access to areas and completing risk assessments.
- Each ward had a clinic room where stock and emergency medications were stored away in a locked cupboard. Emergency equipment, including a defibrillator, was not available on each ward and staff across the adolescent pathway shared emergency grab bags with two wards, Nesbitt and Fenwick. This meant there could be a delay in staff accessing equipment in an emergency. However, the provider supplied us with evidence to show they had risk assessed this and located grab bags at key points throughout the hospital. They had carried out drills to show response times were within what was required.
- All seclusion facilities in use enabled clear observation of patients, had toilet facilities, appropriate mattresses and a clock. All had two-way communication systems (intercoms). However, the two-waycommunication system on Boardman ward had not been working for approximately four weeks. The provider assured us this in no way hindered communication with young people who were being secluded. The provider stated staff and patients could be heard very clearly without the intercom and the intercom was purely there to enhance this communication. Staff told us that the intercom was due for repair the following day. Records confirmed that the seclusion room had been used regularly and recently.
- The wards were clean. However, we observed that some of the wards had numerous scuffmarks and other marks on the walls and would benefit from being redecorated. The wards had adequate furniture to accommodate the young people.
- The wards had adequate hand washing facilities and hand cleaning gels so that staff could adhere to infection control principles. We saw that equipment was well maintained and clean. Each ward had an allocated housekeeper who had up to date cleaning schedules in place. Allocated staff undertook a daily environmental risk assessment.
- Each staff member had a personal alarm. The provider informed us they had made the decision not to offer alarms to the inspection team as inspectors would be escorted at all time. However, we were not escorted at all times on the wards, and were often alone with patients.

Safe staffing

- Ward managers told us there were three reported qualified nurse vacancies across the pathway, two on Boardman and one on John Clare ward at the time of

inspection. Data showed that as of 29 February 2016 there were 80 qualified nurses across the pathway. Staff told us that newly qualified staff had been recruited and were due to start in September 2016.

- There were six health care assistant vacancies across the service and 117 in post at the time of inspection. Some staff had been recruited and were awaiting a start date.
- Each ward utilised bureau (St Andrew's bank) and agency staff; some wards had a higher use than others. All ward staff told us that they have regular bureau staff who work across the pathway, and the use of agency would be a last resort. Staff told us that some agency staff would be familiar to the wards, but not all.
- Data supplied by the provider confirmed that all wards had shifts that were not filled, by either bureau or agency staff. Between 1 December 2015 and 29 February 2016, the pathway had requested 5553 shifts, which required covering due to sickness, absence, leave or vacancies. Of these, 1391 (25%) were not covered by bureau or agency staff across the pathway. This meant that young people did not always receive the care and treatment they required in a timely manner. One young person told us that they had to wait over 30 minutes for a staff member to unlock a toilet. The highest number of shifts not covered was on Boardman ward at 292 and the lowest was on Bayley at 88 uncovered shifts. Staff told us that the wards shared staff when required, but there were occasions when the wards did run below their allocated numbers. The provider told us staff were sometimes requested that were not actually required. This gave a false inflation of agency/bureau need. The provider supplied data which showed the total variances for the period described amount to a deficit of staff of below 10%. Nurse Managers were supernumerary and able to assist where there were staff shortages. Staffing in the pathway has been benchmarked against the quality network for inpatient child and adolescent mental health services standards, which require 20.44 WTE staff for an average 12 bedded unit. All of the adolescent wards met these criteria.
- The staff sickness rate varied across the care pathway between 1% on John Clare, Boardman and Richmond Watson wards, to 5% on Fenwick ward between 01 March 2015 and 29 February 2016.
- Each ward had the staffing levels determined by the occupancy of each ward and the needs of the young people. Managers reviewed staffing levels on a daily basis. Each ward had a minimum number of staff allocated for each shift. If a young person required enhanced observations, this was incorporated in to the current staffing levels. If there were further patients requiring enhanced observations, then the ward manager was able to request more staff to cover these.
- The number of staff on each shift matched the number of staff on the rota on the days of inspection.
- Staff told us that there would always be a regular staff member present to observe young people but it was not always a qualified nurse. Nurses told us that they had good lines of sight from the nursing office.
- Staff told us that there were usually enough staff to facilitate one to one time with allocated patients. However, some nurses told us that while this was planned, there were times that this could be cancelled or postponed due to situations where staff were required to assist with other young people. Staff tried to facilitate regular one to one time with young people regularly.
- Staff told us (33% of those interviewed) that there were occasions when activities or planned escorted section 17 leave was postponed or cancelled due to staff shortages. Of the young people interviewed, 53% reported that they had not been able to access escorted leave due to staffing issues, and 43% told us that they had experienced cancellation of activities due to staffing, particularly when the activities were outside of the building.
- Each ward had allocated medical cover throughout the 24-hour period. There was also a doctor who assisted and worked a twilight shift from 5pm until midnight. The on-call doctor covered the whole hospital. This meant that a doctor was contactable at all times.
- There were enough staff to carry out physical interventions with young people if required. When staff activated the alarms, there would be assistance from other wards.

Assessing and managing risk to patients and staff

- Between 1 April 2015 and 29 March 2016, there were 39 reported serious incidents across the child and adolescent pathway.
- Across the eight wards (excluding Glendale), there were 275 episodes of seclusion between 1 September 2015 and 29 February 2016. Between 29 February 2016 and 1 June 2016 there had been a further 172 episodes of seclusion.

Good

Child and adolescent mental health wards

- Between 1 September 2015 and 29 February 2016 there were seven episodes of young people using long-term segregation. At the time of inspection, one young person was using long-term segregation. The young person had a robust positive behavioural management plan in place; appropriate risk assessments and relevant documentation explaining that this was in the young person's best interests. The young person's parents had been involved in the care and treatment.
- Across the wards, there had been 1307 number of restraints used between 1 September 2015 and 29 February 2016. Of these, 600 (46%) had been in the prone position (face down). The highest use of prone restraint was on Boardman ward with 413. These restraints across the care pathway involved 70 different young people. Staff told us that they would use restraint as a last resort. Staff used de-escalation techniques first, such as talking to the young people or engaging them in activity. Some staff referred to individual positive behavioural support plans, which they referred to as a guide when caring for young people. The majority of staff had been trained in the new management and prevention of aggression course, which put more emphasis upon de-escalation and less emphasis upon physical restraint (MAPA). The provider had changed their restraint training in an attempt to reduce these numbers. Data showed a decline in the use of prone restraint in the adolescent service during the previous 13 months and ongoing monitoring of the use of restraint was in place. Although benchmarking or comparison with other adolescent services is difficult because St Andrew's take patients with more challenging needs there is no evidence to suggest the use of restraint is particularly high in this service.
- We examined 37 care records during the inspection. We found that staff undertook a risk assessment of each young person upon admission and the majority of risk assessments were updated accordingly.
- Staff used the short-term assessment of risk and treatability tool (START) risk assessment.
- Staff on some wards locked off bedroom corridors throughout the day, although stated that young people could access these if they wanted to. Young people interviewed told us that bedroom access would be dependent upon the staffing levels and their safety level. The provider informed us corridors were never locked off because there were not enough staff. They said they changed the way in which care was organised to make sure that the area was covered.
- There were two informal patients across the service at the time of inspection. Staff told us that informal patients could leave the wards if they wished. We saw that there were posters for informal patients informing them of their rights. We observed that staff would need to let informal young people out due to the security levels within the hospital including the locked doors and air locks to access the main reception.
- We saw that the service had policies and procedures in place for the use of supportive observations, and for the searching of patients. We observed however, that staff were searching some young people (pat down) in a corridor, even though there were private rooms available. This compromised young people's privacy and dignity.
- Staff were not adhering to the National Institute for Health and Care excellence (NICE) guidelines when administering rapid tranquillisation. Some staff told us that they did not routinely monitor physical health (blood pressure, temperature and pulse) following administration but they would visibly observe the young person. We found no evidence in records of staff undertaking visual observations following administration of rapid tranquillisation or of recording level of alertness if monitoring was not required.
- The service had a seclusion and long-term segregation policy in place of which staff were aware.
- Staff interviewed, had a good understanding of when to report safeguarding concerns and who to report to. Staff were able to talk through the procedure in line with the policy.
- We observed good medicines management practice, in terms of transporting, dispensing and medicine reconciliation.
- The pathway had adequate facilities and rooms for children and families who visit the service.

Track record on safety

- There had been 39 serious incidents reported across the eight wards between 1 April 2015 and 29 March 2016.

Reporting incidents and learning from when things go wrong

Good

Child and adolescent mental health wards

- Staff we spoke with told us what incidents needed to be reported and were aware of how to report these. Bureau and agency staff were able to complete incident forms.
- Ward managers told us that they were open and transparent with patients and relatives and tell them if things go wrong. One carer we spoke with confirmed this.
- Ward managers received incident forms and were aware of what had been reported on their own wards. Staff discussed incidents in the weekly multi-disciplinary meetings at ward level. Ward managers attended senior management meetings where incidents were on the standard agenda. It was the responsibility of the ward managers to ensure that relevant information was cascaded to their staff. Ward managers told us that all staff received emails and notifications known as "hot topics" about incidents and lessons learnt.
- Staff told us they did not always receive a de-brief following incidents, unless it was significant. We were told of a significant incident and care records indicated that the young person had received a de-brief about this but there were no records to indicate that staff had. A ward manager confirmed that this was not always recorded at ward level. Within the adolescent service, the psychology department ran the debrief sessions, there were also clinical supervision, reflective practice and formulation meetings in which staff received de-brief.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We examined 37 care records during the inspection. We found that all patients had a comprehensive and timely assessment following admission.
- We saw that patients received a physical examination by the doctors on admission and there were records to reflect ongoing monitoring of physical health problems such as diabetes or obesity.
- We examined four records of young people who had been prescribed anti-psychotic medications. Staff did not complete physical health monitoring in accordance with doctors clear guidelines upon prescribing. We saw that nurses had not been consistently recording physical observations upon initiation of medications as advised by guidelines. We asked nurses, ward managers and the modern matron where such recording would be, and were told by all that these would be found with the medication charts (on a paper recording form) and on the electronic database within the physical observations section. We looked for paper records and only found incomplete initiation forms. The electronic records showed some records of physical observations, but not always. The modern matron was informed of this and said that she would address with the staff. We saw that nurses were not routinely recording the physical health observations of young people who had received rapid tranquillisation or recording their alertness level if monitoring was not required.
- We saw that patients had comprehensive positive behavioural support plans in place. These were personalised and holistic. Staff and young people told us that these were used in conjunction with their safety levels. Some young people told us that they did not understand the safety levels, and what they needed to do to progress through the levels. Staff explained that as they progressed up the safety levels (from one up to six); the psychiatrist would grant more leave. This system was being phased out.
- The provider held all care notes electronically and so if young people were transferred to another ward within the hospital, the receiving team would have immediate access to these.

Best practice in treatment and care

- Doctors adhered to the National Institute for Health and Care Excellence (NICE) guidance when prescribing medications.
- The pathway offered a range of psychological therapies, such as dialectical behavioural therapy, sex offender treatment and fire setting interventions.
- The pathway had access to different healthcare professionals within the hospital. There were physical healthcare facilitators who could assist ward staff with young people's physical healthcare needs, as well as some healthcare assistants who had been trained to work as trainee assistant practitioners (TAPS). These would assist the ward staff for example with blood

taking, physical observations and booking of medical appointments for young people. Physiotherapists, speech and language therapists and dieticians were easily accessible if required.
- Staff completed HONOS (Health of the nation outcome scale) which is a recognised tool to assess and record severity and outcomes.
- Ward staff participated in regular clinical audits such as environmental audits, mattress audits, medication chart audits and health and safety audits. Pharmacists and assistants would undertake medication audits, and staff told us that the Mental Health Act administrator would report on audits around Mental Health Act documentation.

Skilled staff to deliver care

- Each ward had a range of mental health disciplines to provide care to young people across the pathway. There was a pharmacy on site, with dedicated technicians for the adolescent pathway. Each ward had allocated psychiatrists, occupational therapists, technical instructors, psychologists, social workers, nurses, and healthcare assistants. The team included teachers who focused upon the educational needs of the young people. Staff had a vast range of skills, experience and qualifications to enable them to meet the needs of the patients.

- All substantive and bureau staff attend the hospital's corporate induction. This includes undertaking mandatory training such as safety and security; safeguarding of vulnerable adults; health, safety and welfare, management of actual or potential aggression (MAPA) and basic life support (BLS). Additionally, staff were expected to undertake further training via e learning within one month of employment, which included information governance, equality, diversity and human rights and infection control. The provider told us that each care pathway was responsible for organising and delivering a more specific local induction to employed staff. Staff told us that the local induction for this pathway was in the process of being updated as previous staff who assisted with the delivery had left the service. Most staff interviewed could not recall having specific training around caring for children and adolescents, or receiving information around the Children's Act (2004).
- Bureau and agency staff were welcomed to the allocated ward and given a hand-over from the nurse in charge at the beginning of their shift. The provider told us that training requirements and expectations were within the contracts with the agencies.
- Staff told us that they received regular supervision on a monthly basis. The qualified nurses had one to one sessions. The healthcare assistants had a range of one to one sessions, group peer supervision and reflective practice. The hospital's target for staff supervision was 95%. At the time of inspection, six of the eight wards had achieved this.
- Staff told us that they received annual appraisals. We saw documents that reflected this across the service.
- Staff told us that they had the opportunity to attend regular staff meetings. Ward managers confirmed that they worked different hours to facilitate this and to meet with all staff on a weekly basis. The ward managers held records of meetings.
- Ward managers addressed poor staff performance with the support from senior managers and the human resources staff.

Multi-disciplinary and inter-agency team work

- On each ward, staff held a weekly multi-disciplinary team meeting with the young people, which gave them an opportunity to discuss their care and treatment.
- Staff gave a hand-over of information to the staff on the oncoming shift, which included an overview of young people's progress and details of any incidents or areas of concern. The staff member conducting the hand-over would state each individual's observation levels and safety levels.
- We saw that ward staff had good working relationships with other external teams, for example community mental health teams and care co-ordinators. Staff invited relevant professionals to care programme approach meetings, and if they could not attend, staff would facilitate a teleconference or a phone to offer participation.

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

- Training on the Mental Health Act (MHA) was conducted via e learning for all clinical staff. All new staff were

expected to have completed this within the first four weeks of employment. Qualified staff we spoke with demonstrated an understanding of the Mental Health Act (1983).

- Staff adhered to consent to treatment and capacity requirements. Copies of the consent to treatment forms were alongside the medication charts and were held electronically.
- We saw that patients had their rights under the Mental Health Act explained to them upon admission. Rights were also explained and available in easy read formats. Staff told us that they routinely discussed rights under the MHA every six months. A Mental Health Act administrator offered support and advice around the MHA and the code of practice. Ward managers told us that the administrator would alert them when rights under the act needed to be re-visited, and when reports were due relating to managers hearings or Mental Health Act review tribunals. However, not all young people had these re-read to them upon renewal of detention or upon a change in detention.
- Staff completed detention paperwork correctly. It was up to date and stored appropriately.
- All young people had access to an independent mental health advocate (IMHA). Each ward had visible written information and telephone numbers for this service.

Good practice in applying the MCA

- Training on the Mental Capacity Act (2005) and the Deprivation of Liberty safeguards (DoLS) was via e learning for all clinical staff. All new staff were expected to have completed this within the first four weeks of employment.
- There were no DoLS applications across the service between 28 August 2015 and 21 January 2016.
- Nurses and healthcare assistants did not have a good understanding around the MCA. Staff told us that they would refer a young person to the social worker or the doctor if there were concerns around capacity. Most staff we spoke with had not been involved in a capacity assessment. There was however, evidence of appropriate use and application of the MCA and best interests decisions on Bailey ward for one young person.
- Staff were aware of the policy on the MCA including DoLS. Staff told us that the Mental Health Act administrator was also available for advice around the MCA if required. Staff told us that they would always support a young person to make decisions for themselves where possible.
- Senior staff were aware of Gillick competence when determining a child's capacity to consent. Gillick competence is the principle used to judge capacity in children to consent to medical treatment. Senior staff were also aware of the Fraser competence, which relates to a child under 16 who is deemed competent to receive contraceptive advice without parental knowledge.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

- We saw some caring and positive interactions between staff and young people on the wards. Young people felt that generally, the staff were kind and supportive of their needs.
- Staff we spoke with had a good understanding of the young person's day to day needs.
- We saw that some young people were being searched in a corridor where others could see, despite there being a vacant room available close by.

The involvement of people in the care they receive

- There was a planned admission process across the service. When young people arrived at the hospital, they received relevant written information about the ward. The service also had a video, made by young people with experience of using the service. Individuals were encouraged to watch this. Staff could facilitate a visit to the service if appropriate for the young person and their family. The wards had a "buddy" system in place so that an allocated young person on the ward would introduce them to peers and staff. One young person told us how valuable this was when they were admitted to the service, as they felt scared but were welcomed and reassured.
- Young people told us that they felt involved in their care and treatment and could have copies of care plans if they wanted. They had the opportunity to attend multi-disciplinary meetings.

Good

Child and adolescent mental health wards

- Young people told us that they had access to advocacy. Staff would assist them if felt necessary. The phone number was available and visible on each ward.
- Young people and carers told us that families were actively involved in the care and treatment discussions. Members of the multi-disciplinary team would make contact when necessary with families.
- Each ward held weekly community meetings, which gave young people the opportunity to give their feedback. There was also a monthly, "service user group meeting", where representatives from each ward across the adolescent pathway could attend and participate. This gave young people the opportunity to feed back to others on their wards of any upcoming events or initiatives.
- One young person had recently attended a staff recruitment open day with the ward manager. Staff told us that where possible, young people were encouraged to participate in the recruitment process.

Are child and adolescent mental health wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- Bed occupancy rates varied across the wards between September 2015 and February 2016, between 70% on Richmond Watson ward, to 96% on Church ward.
- The service received young people from all over the country. Staff told us that they would work with the individual's local teams to accommodate a placement closer to home if possible when looking to transfer or discharge a young person.
- Staff would not transfer young people between wards for non-clinical reasons.
- Staff planned discharges and therefore they occurred at appropriate times during the day, in collaboration with families or other professionals as relevant.
- There were five delayed discharges on the wards at the time of the inspection. Ward managers and carers told us that any delay in discharge was due to locating a suitable placement to meet the needs of the young person. Ward managers attended weekly bed management meetings to discuss admissions, discharges and delayed discharges.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had a range of rooms and equipment to support care and treatment of young people. The therapy suite had ample space and equipment for educational, leisure and therapeutic activities. Each ward had a clinic room with a couch so that staff could undertake physical examinations. Within the extensive hospital grounds, there was a gym and a swimming pool.
- The service had rooms to accommodate visitors, both adults and children. Each ward had its own small telephone booth, which enabled young people to make telephone calls in private.
- All wards had direct access to outside space so that they could get fresh air.
- The service offered a four weekly rotating menu with summer and winter menu changes. Additionally there was a monthly themed menu. Young people interviewed gave a varied response to the foods offered.
- Cold water dispensers were located on the wards with plastic cups. Young people were offered hot drinks at regular intervals throughout the day, and outside of this young people could request staff make them a hot drink
- We saw that young people were able to personalise their bedrooms. Each bedroom had lockable storage space. This meant that individuals had somewhere secure to store their possessions.
- We saw that there was access to activities on a daily basis. The occupational therapist and technical instructor worked Mondays to Fridays. Ward staff facilitated activities over the weekend.
- On one ward, we found that there was a blanket restriction on toilet rolls. Young people had to ask for this when requiring the toilet. This was because three had been recent incidents of a young person ingesting this. However, the multidisciplinary team and modern matron with a view to relaxing the blanket restriction were reviewing all young people on the ward.

Meeting the needs of all people who use the service

- The service could accommodate young people who had a physical disability or required a wheelchair.

Good

Child and adolescent mental health wards

- Staff told us that information leaflets available to young people were in English, although they could access information in other languages as and when required. Staff told us that there had been occasions whereby the team (nurses, occupational therapists and the speech and language therapists) would put together specific easy read documents to aid a patients understanding. Ward staff told us that they have access to an interpreter and some staff across the hospital were trained in sign language.
- The service provided accessible information on treatments; local community services; rights under the Mental Health Act (1983); how to make a complaint and how to access advocacy.
- We saw that young people had a choice of food to meet individual dietary requirements.
- Staff and young people told us that there was access to spiritual support for patients of different faiths, beliefs and religions.

Listening to and learning from concerns and complaints

- Between February 2015 and January 2016, there were 55 complaints across the eight wards. Of these, following investigation, staff upheld nine. No complaints had been referred to the Independent Sector Complaints Adjudication Service (ISCAS).
- Young people we spoke with told us that they knew how to make a complaint. Staff we spoke with told us that complaints received were escalated to the ward manager, or the modern matron as appropriate. An investigation would then commence, and a senior staff member would complete this.

Are child and adolescent mental health wards well-led?

Good

Vision and values

- Staff we spoke with had an understanding of the provider's vision and values.
- Staff could tell us who the senior managers were within the pathway, and confirmed that the modern matron is very visible and visited the wards on a regular basis. Staff felt that not all young people would know the name of the senior managers but would recognise them if on the ward.

Good governance

- Overall, across the pathway 91% of staff had received mandatory training. The lowest rate across the wards was on Boardman ward at 78%. Staff had received an annual appraisal and regular supervision.
- The pathway strived to cover all shifts with a sufficient number of staff with the right qualifications and experience.
- Staff participated in clinical audit to monitor the service provision and quality.
- Staff received lessons learnt from significant incidents that have occurred across the pathway.
- Most staff across the pathway had received newly introduced training around the management of actual or potential aggression (MAPA).
- We saw the monthly "modern matron's dashboards" which collated and displayed information on incidents, restraints, safeguarding, falls and medication errors. These were displayed on wards for staff.
- Ward managers we spoke with said they had sufficient authority to do their job and had adequate administrative support.
- Ward managers could raise risks with senior managers to be included on the hospital risk register.

Leadership, morale and staff engagement

- There was no active bullying or harassment cases ongoing at the time of inspection.
- Staff told us that they were aware of, and knew how to use the hospital whistle-blowing policy. One staff member relayed how this had helped them in the past and found it to be a supportive process. Staff told us that they felt able to raise concerns with senior staff.
- Morale across the service appeared good. Staff we spoke with clearly enjoyed their roles.
- Ward managers had opportunities for leadership development and felt supported with training to enhance their knowledge in their roles.
- We saw good team working across the wards and staff were supportive of each other.
- Staff told us that they were open and transparent with patients and would tell them if things went wrong. A carer we spoke with confirmed this.

Good

Child and adolescent mental health wards

- Staff had opportunities to give feedback on services and input into service development. One ward manager told us that they were going to pilot electronic prescribing in the near future. Another ward manager told us that they were one of three wards to trial using internet software to speak with relatives who could not attend in person.

Commitment to quality improvement and innovation

- One ward manager told us that the care pathway was launching a new risk management tool in the future, which is awaiting accreditation.
- The adolescent pathway had undergone a quality network review. The provider told us that they were awaiting the report.

Good

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Good

Safe and clean environment

- The provider had not ensured staff were able to observe all parts of the ward. O'Connell ward had some mirrors in place but these did not mitigate all blind spots. On Foster and Compton wards, there were no mirrors to reduce the risk posed by blind spots. Staff told us they reduced the risk with direct observations of patients. However, Foster ward had several corridors where monitoring blind spots could be difficult, as this required a staff member to observe each corridor at all times. The provider told us management of the physical environment was considered as part of relational security exploration. This is, reviewed on a continual basis from the perspective of the ward teams as well as the care pathway's senior management team.
- There were ligature points on all wards except Cranford ward. These included taps, windows, door handles, and light fittings. We reviewed ligature risk assessments which highlighted the different ligature risks, with an action plan. The provider told us they did not intend to remove all ligatures but mitigated risks and took into consideration the type of ward.
- Compton ward was a mixed sex ward. They adhered to mixed sex guidelines by having separate male and female sleeping areas. There were separate male and female lounge areas. The female lounge above the female bedroom area was accessible to female patients throughout the day. The door to the female bedrooms from the mixed lounge area was locked and only accessible by the staff. This meant that female patients did not have free access to their bedrooms during the day, although staff observed this area continuously so access was given when requested.
- Resuscitation equipment was not always readily accessible to wards. Foster and Compton ward did not have resuscitation bags in the clinic room and would have to access this equipment from other wards. Staff would have to activate their pinpoint alarms and call via radio system to request resuscitation equipment. Staff would have to navigate through several locked doors to get to where they needed to be. This could cause delay in responding to emergencies. Staff told us that the resuscitation bags could arrive within three minutes but a delay could put patients at unnecessary risk of harm. However, the provider supplied us with evidence to show they had risk assessed this and located grab bags at key points throughout the hospital.
- Clinic rooms had appropriate equipment to monitor the physical health of patients. We reviewed the audit of equipment checks and found that staff checked the equipment on a weekly basis.
- Seclusion rooms met with the standards of the Mental Health Act code of practice.
- Staff kept all ward areas clean and we saw cleaning records were completed and up to date.
- All wards had a variety of equipment available such as hoists, wheelchairs, and walking frames. We reviewed the equipment-cleaning audit and found that staff cleaned and checked the maintenance of equipment on a weekly basis.

- Wards had storage rooms for the equipment. However, O'Connell ward was cluttered and some equipment such as the hoists was not easily accessible in case of an emergency.
- Staff had personal alarms. These alarms allowed staff to summon assistance when they were at risk or needed help. Display panels around the wards showed the location of where staff had raised the alarm so that other staff could respond quickly. However, the provider did not offer us alarms when we went onto the wards as they had made the decision not based on the fact we were meant to be escorted at all times. Bedrooms had nurse call systems so patients were able to seek support from nursing staff.

Safe staffing

- The staffing establishment for Compton ward was 12.5 whole time equivalent (WTE) qualified nurses and 14 health care assistants. There was one vacancy for a health care assistant. Cranford ward had nine qualified nurses and 18 healthcare assistants. They had two vacancies for qualified nurses and one vacancy for health care assistants. Foster ward had 11 qualified nurses and 15 health care assistants. They had three vacancies for health care assistants. O'Connell ward had 13 qualified nurses and 28 health care assistants. They had 12 vacancies for health care assistants. For O'Connell the staff establishment was 20.1 WTE qualified nurses and 31.4 WTE health care assistants. At the time of the inspection there were no qualified vacancies and five WTE health care assistant vacancies.
- The provider used a recognised tool for estimating staffing numbers on each shift. This looked at staff need on wards and allowed managers to plan staffing numbers to manage workload safely.
- The provider did not always demonstrate safe staffing levels on all shifts. We checked the duty rotas for the wards, which showed the provider was not always able to provide an adequate number of staff. On Compton ward between 29 May and 25 June there were nine days with no adequate qualified nursing cover. On O'Connell ward between 22 May and 18 June, two night shifts did not have any qualified staff. The duty rotas showed on these night shifts, there were only two healthcare assistants on shift. On Cranford ward between 6 June and 12 June they failed to meet their staffing establishment every day.
- The provider filled an average of 25 to 30% of their shifts with bureau and agency staff. We checked the duty rotas for each ward over the past months, which showed the provider was using regular bureau staff to cover shifts to maintain continuity of care for patients.
- However, ward managers said they were able to increase staffing to manage activity levels and risks on the ward. Staff told us the provider increased staffing to support patients with planned leave and increased observations. We checked the duty rotas for wards and found days where the provider had increased staffing numbers. On Cranford ward between 23 May and 12 June, there were five days where the provider had increased staffing numbers. On O'Connell ward during the same period, there were seven days where the provider had increased staffing numbers to manage activity levels or patient risk.
- Managers told us they increased staffing numbers to facilitate Section 17 leave. Patients we spoke with told us that they had not had leave cancelled due to staffing issues. The occupational therapist team planned activities. Patients told us staff never cancelled activities. However, the provider did not always have enough staff to carry out physical interventions safely. The duty rotas for all wards showed that on at least 13 occasions they were short of two staff on the shift. This meant it would be difficult to manage the care needs of patients in a safe way.
- Staff were present in communal areas on all wards we visited. On Cranford ward, there was a staff member located in the bedroom corridors to monitor patients. On Compton ward, staff were located in male and female lounge areas as well as in bedroom corridors. This meant staff were available should patients need assistance or support.
- The provider had adequate medical cover to respond quickly in an emergency. This included an out of hour's duty rota for doctors.
- The provider supplied mandatory training compliance data which showed 91.5% compliance. Staff were required to attend a variety of mandatory training courses. These included manual handling, management of actual or potential aggression training (MAPA), basic life support, safeguarding, and infection control as well as various other different training appropriate to staffs' roles.
- Managers had access to electronic dashboards, which showed staff compliance rate with mandatory training.

Managers told us they would receive an e-mail prompting them when staffs mandatory training was due for renewal. Managers passed this information on to staff, making it their responsibility to book the next available course.

Assessing and managing risk to patients and staff

- The service had low incidents of seclusion in the last six months. Cranford ward used seclusion six times in the previous six months. We checked the records of seclusion and found evidence that doctors were attending within an hour of seclusion commencing. We found evidence that doctors attended every four hours after this. Staff provided patients with food and drinks throughout their time in seclusion. Staff monitored patients' physical health whilst in seclusion, in line with the provider's policy. Staff were using seclusion appropriately and in accordance with the MHA code of practice.
- O'Connell, Compton, and Foster wards had no seclusion facilities. O'Connell ward had a high rate of restraint. However, in this service, due to the nature of the service users' symptoms associated with their diagnosis, there are times when staff had to implement the use of restraint in order to support patients with their basic personal care. This provider records all incidents of hands on care as restraint. There had been 501 uses of restraint in the previous six months, of which five were in the prone position (held facedown) this involved 16 different patients. On these five occasions, staff used prone restraint for the administration of rapid tranquilisation medication. Compton ward had used restraint twice in the previous six months. None of these restraints was in the prone position. Foster ward had only used restraint once.
- Staff told us they documented any hands on intervention as a restraint. This meant that staff were de-escalating situations appropriately and using least restrictive practice. Staff were documenting restraint appropriately and in line with the provider's policy.
- Staff undertook risk assessments of each patient when they admitted them to the wards. We reviewed the care records of 20 patients and saw each patient had a thorough risk assessment in place. The provider used the historical clinical risk 20 (HCR–20) assessment tool. This is a comprehensive risk assessment tool that staff used to chart the patient risk history throughout their illness.
- Informal patients were able to leave the ward upon request. Only Compton ward had informal patients admitted. Doors in and out of the ward were locked to manage patient risk. This meant that informal patients had to request staff let them out should they wish to leave. However, there were no restrictions placed on informal patients around leaving and returning to the ward when they asked.
- Robust policies and procedures were in place for the use of observations on all wards. Staff used different levels of observations on patients dependent on individual risk. This ranged from general observations (one hourly) to 15 min checks and one-to-one observation (staff member present at all times). We reviewed the observation records, and found staff filled these in correctly and there were no gaps.
- Staff used rapid tranquilisation appropriately and in line with the provider's guidance. We reviewed the medication cards of patients who staff had administered rapid tranquilisation too, and saw it had been prescribed had administered appropriately.
- Staff we spoke with showed a good understanding of safeguarding and their responsibilities in reporting any concerns. Training records showed 90% of staff were compliant with safeguarding training. Staff were able to describe signs of abuse and actions they would take if they had any concerns. Examples they provided included reporting concerns to the nurse in charge or line manager. The social worker made safeguarding referrals to the local authority and reported these to the Care Quality Commission. The provider held safeguarding meetings in which they discussed concerns and action plans. We saw evidence staff documented these meetings and action plans in patient's notes.
- All wards had effective medicines management procedures in place. The nurse in charge held the keys for the medicines cupboards to ensure accountability. This included the controlled drugs cupboard key. The provider used stock medication as well as patients' own medications. Patient's medication was labelled appropriately. We checked a range of medications and found that they were all within the expiry dates.
- We checked 20 medication records, which completed correctly with dose, frequency, and time of medication administration. However, on O'Connell ward we found two medication records where staff had not signed the medication form. Staff had highlighted this within the

Good

Wards for older people with mental health problems

clinical audit of the medication records and staff took action to rectify this. A pharmacy within the hospital site provided the wards with medication. A pharmacist attended wards every two weeks to check and replenish stock.

- Staff knew how to address issues relating to falls or pressure ulcers. Patients had a falls risk assessment completed. This included an environmental risk assessment. Staff would increase observation levels if a patient was at high risk of falls. Staff were aware of procedures to manage pressure ulcers. Staff told us they had to report grade three and four pressure ulcers as a safeguarding issue.

Track record on safety

- There had been 17 serious incidents requiring investigation (SIRI) across the older adult service in the past 12 months. There were 10 SIRIs on O'Connell ward, three on Foster ward, two on Cranford ward, and two on Compton ward. The main themes of these SIRIs were falls, physical health emergencies, and expected deaths. We reviewed the incident data. The provider investigated the incidents and they identified lessons to be learned.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. Staff told us they reported incidents of violence and aggression, slips trips and falls, pressure ulcers, near misses and any other adverse events. The provider used an electronic system for reporting incidents.
- We reviewed incidents reported over the past month, which showed that staff had reported incidents appropriately.
- Staff received feedback from investigations, and provider informed them of any lessons learnt. The provider would send out "red top" e-mail alerts. These contained information on the outcomes of investigations and lessons learnt from incidents across all provider locations. This meant that there were shared learning from incidents across all services.
- Staff discussed feedback within multidisciplinary team meetings. Meeting minutes demonstrated that staff discussed lessons learnt from incidents.
- We found evidence of changes because of lessons learned. An example was the introduction of audits to reduce the number of times staff failed to sign medication cards. Since the provider introduced these audits, incidents had reduced.
- Senior staff debriefed staff following serious incidents. Staff came together to discuss incidents that had occurred, including what went well, what they could have done better and what might have prevented the incident. Staff told us they offered patients debriefs following incidents. However, the patients we spoke with were unable to corroborate this.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We reviewed 20 care records. Two staff completed pre-admission assessments to see if they could meet the patient's needs within the service. If the service could not meet the patient's needs, staff were able to refuse admission and suggest alternatives. Following admission, a further assessment of the patient's needs took place over a two-week period. Staff used this information gained to develop a care plan to meet the patients' needs.
- Doctors carried out physical health observations upon patient admission to the wards. We found evidence in the care records that the practice nurse carried our basic physical health checks on a monthly basis and liaised with the doctor regarding physical health concerns. This included monitoring blood pressure and weight. Care plans documented when patients required additional health care monitoring, for example patients with diabetes. The provider trained staff to monitor blood sugars and reported concerns to the practice nurse.
- Care plans were recovery focused, identifying patients' needs in a holistic way that focused on individual strength and goal setting. Staff met with patients at two weekly reviews and if a patient's needs had changed, the care plan was updated. Care plans were free from medical jargon so patients could relate to and understand them.

- All care records were stored securely on an electronic system to which all staff, including bureau and agency staff, had access. Some information, such as care plans, was kept in paper format. The staff kept paper records in a locked filing cabinet in the nurse's office.

Best practice in treatment and care

- On Compton and Foster wards, staff told us they followed National Institute for Health and Care Excellence (NICE) guidelines for prescribing antipsychotic medication for older adults with dementia. Most patients who required this type of medication received low doses in line with best practice and they received yearly annual health checks.
- Staff used GASS (Glasgow Antipsychotic Side Effect Scale) to monitor people for side effects from medication. We saw these completed in care notes. However, on Foster ward, staff treated one patient with high levels of antipsychotic medication, but staff had not carried out a GASS assessment. This was in spite of the patient being prescribed medications to alleviate side effects. We discussed this with the manager who told us it was an oversight. The manager reviewed this immediately. Staff had not identified this through medication audits and reviews.
- The provider offered a range of therapies recommended by NICE. These included occupational therapy designed to help improve patients' quality of life. The psychology team offered cognitive behaviour therapy where appropriate.
- A practice nurse on site managed patients' physical health care. However, if patients had more complex physical health needs, we saw from care records that staff had made appropriate referrals to specialist health care professionals. A number of patients had epilepsy and received support from the neurology department at the local general hospital. Staff had access to the local diabetes team, opticians, and audiologist. There was a GP surgery on site, and the practice nurse had direct access to the doctors.
- Electronic records demonstrated that staff carried out the MUST assessment, a nutritional assessment, to monitor patient's nutritional needs. It included management guidelines, which staff used to develop a care plan. Patients who had difficulty swallowing had received a speech and language therapist assessment and staff wrote care plans to meet patients' nutritional needs in a safe way. For example, using special thickening agents in liquids and liquidising foods to make it easier for them to swallow. Staff referred patients to the dietitian if patients needed a specialist diet. Food was modified to each patient's individual requirements in a specialist diets kitchen.
- Clinical staff completed health of the nation outcomes scales (HoNOS), a recognised tool for measuring patient's improvements from admission to discharge. Staff recorded these in patient's clinical notes.
- Staff participated in both monthly and weekly clinical audits. These included care plans, risk assessments, health and safety audits, and medication records audits. We observed that these were completed in full and that when issues were identified, these were acted on.

Skilled staff to deliver care

- There was a wide range of professionals which contributed to patients' care. This included nurses, health care assistants, psychiatrists, psychologists, occupational therapists and social workers. Physiotherapy was available on the hospital site should patients require it. All staff had the necessary experience and qualifications required for their role.
- Staff had a period of induction when they started work with the provider. Staff spent the first two weeks of their employment undertaking mandatory training requirements. Staff then spent three days shadowing another staff member to orientate them to the ward and learn about patients' needs.
- Staff did not have structured management supervision. Supervisions occurred monthly by peers rather than line managers. Over a three-month period, we found evidence that two members of staff had supervised each other. In order records, we found that staff had chosen a different supervisor every month. This meant the provider could not ensure staff were being appropriately monitored and performance managed. Information gained from staff during supervisions was not used to assess the quality of care provided, nor were problems that the service needed to address as a whole. However, staff chose who provided them with clinical supervision as per the provider's policy.
- Staff had access to specialist training. The provider had a learning directory which staff used to select relevant training develop their skills. Staff told us they had completed specialist dementia training and dementia care mapping training.

Good

Wards for older people with mental health problems

Multi-disciplinary and inter-agency team work

- Team managers chaired monthly multidisciplinary team (MDT) meetings on each ward. Consultant psychiatrists, ward managers, psychologists, occupational therapists and clinical nurse leads attended meetings to discuss patient care plans and presenting risks. Meeting minutes demonstrated that staffing levels, specialist training needs, and best practice guidelines were reviewed.
- We observed two care reviews on Compton ward. Patients admitted to Compton ward had a diagnosis of dementia. We saw care reviews were comprehensive and looked at all of patients' needs holistically. Staff attempted to engage patients in the process, however, one patient declined to get involved.
- Staff attended handovers at the end of each shift to discuss each patient, their presentation during the day and any changing needs. Staff discussed the potential need for additional support or wider MDT advice given during the day.

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

- Staff received mandatory training in the Mental Health Act 1983 (MHA) and MHA code of practice as part of their induction. Staff were required to undertake updates from the provider's current issues in mental health law course. This was designed to cover significant changes to the code of practice. In spite of the training being mandatory, the provider did not provide us with statistics that demonstrated how many staff had attended this training across the four wards. The data that the provider supplied demonstrated from June 2015, 82% of staff from across the service had received training. We could not be sure staff had a good understanding of any changes to the act to support them in caring for detained patients.
- Medical staff completed consent to treatment and capacity forms. For patients with capacity T2 forms were completed. Second opinion appointed doctors (SOAD) were used appropriately to provide assessments of patients deemed to lack capacity, and completed T3 forms to demonstrate this. The role of the SOAD is to decide whether the treatment recommended is clinically based and whether due consideration had been given to the views and rights of patient. Nursing staff attached the T2 and T3 forms to the front of medication cards to ensure that nurses administered medication in accordance to the MHA.
- Nursing staff did not always adhere to MHA code of practice. Nursing staff attempted to read people their rights and restrictions under the Mental Health Act (Section 132 forms) when detained. However, we found on Foster ward that three of the six 132 forms for patients lacking capacity were not revisited with patients in a timely way in line with the Mental Health Act code of practice. MHA administrators had not identified this as an issue.
- MHA administrators supported staff by carrying out regular audits of MHA paperwork and highlighted errors to staff to ensure that patients remained legally detained and safeguarded. The MHA administrator coordinated MHA hearings and tribunals for patients. Staff told us they were able to access MHA administrators for legal advice in addition to administrative support.
- MHA paperwork was safely stored in the MHA administrator's office. Staff scanned copies onto the electronic system and placed in patients care notes. Of 13 patient MHA records reviewed, staff had not scanned one patient's MHA records onto the electronic notes. This meant staff might not have access to them when needed. However, we highlighted this to the MHA administrator's team who rectified this immediately.
- Staff supported patients to access leave and staff regularly reviewed Section 17 documentation to approve leave during care reviews.
- Patients had access to independent mental health advocates and staff supported patients to self-refer to this service. The provider displayed details around the wards informing patients of how to access the service.

Good practice in applying the MCA

- Staff completed training in the Mental Capacity Act 2005 (MCA) as part of their induction to the service. However, staff did not receive mandatory updates in the MCA. The provider showed us data that demonstrated from June 2015, 82% of people across the whole service had undertaken this training which they combined with training on the MHA. Consequently, we could not be certain that staff had the necessary knowledge to adhere to MCA best practice.

Good

Wards for older people with mental health problems

- Unqualified staff did not have a good understanding of the principles of the MCA. Only one of the healthcare assistants we spoke with was able to demonstrate a basic understanding of the MCA. Unqualified staff spent most time with patients attending to their care needs. Consequently, we could not be confident that staff considered issues relating to capacity and consent. Qualified staff we spoke with had a good understanding of MCA and we found evidence of this in MDT meetings minutes and in patient care plans.
- The provider had policies in place for the MCA 2005, and DoLS. Staff knew how to access this information from the provider's electronic computer system.
- Qualified staff updated electronic records relating to capacity decision specific questions. However, on Foster and Compton wards we did not find evidence of how staff had concluded that patients lacked capacity. Staff listed all the decisions where they felt a patient lacked capacity but we did not see evidence supporting these decisions, for example with appropriate decision specific mental capacity assessments, including who had been involved in making the decisions such as best interest assessors and advocates. Therefore, we could not be confident that staff had taken all practicable steps to enable patients to make their own decisions. On O'Connell and Cranford wards staff organised best interest meetings for patients that lacked capacity.
- Staff told us if they needed support with information relating to the MCA and DoLS, they were able to seek advice from the MHA administrators and the social work team.
- Staff made appropriate DoLS applications for patients who lacked capacity, but did not meet the criteria for detention under the MHA.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

- Staff were observed interacting with patients in a kind and respectful manner. However, on Cranford ward we observed staff pat searching patients returning from leave in communal areas. Pat searching is when staff checked patients had not brought any contraband items onto the ward and this involves staff patting patients' arms, legs and body. Carrying this out in communal areas did not protect the patients' dignity and privacy. This was not in line with the provider's policy and procedures which state staff should carry out searches whilst protecting patients' privacy.
- We spoke with four patients who informed us that staff were caring and supportive. We observed good relationships between staff and patients. Patients told us that staff responded to their needs and were approachable if they had any concerns.
- Staff showed good understanding of patients' needs. Many of the patients had been detained in hospital for long periods. During that time, staff had become familiar with patients' preferences and individual needs.

The involvement of people in the care they receive

- Patients were orientated to the ward on admission in a sensitive manner. Patients received a welcome pack that gave them information of how the wards were run and what activities and support would be available to them. We observed that patients kept welcome packs in the bedrooms for reference.
- Patients were involved in the planning of their care when able. Staff documented patient views in their care plans and documented when patients had been unable to be involved due to high levels of confusion. When patients were unable to be directly involved in planning their care, staff used the "This is me" document which is a tool for people with dementia to complete that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes.
- Staff completed positive behaviour plans with patients where possible. These plans informed staff how to best support patients when distressed and agitated. This included information about how the patent would like to be treated. For example, how they could be distracted or comforted in times of distress based on their preferences. The "This is me" information gained from patients, relatives and carers, helped to inform these plans.
- Staff offered patients copies of their care plans, but they did not always want them. Staff documented refusals in care records. Patients could access independent advocacy services in addition to IMCAs and IMHAs. Staff displayed information on how to access this service in communal areas.

Good

Wards for older people with mental health problems

- Staff told us that they held monthly community meetings on each ward where patients could feedback on issues that mattered to them, although we did not see minutes for these meetings. However, on Compton ward staff told us that community meetings had not worked due to lack of attendance by patients, consequently, they had considered the patient group need and held a tea party. Staff would engage with patients over a cup of tea and a piece of cake to see if they had any issues of concern about the ward.

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

(for example, to feedback?)

Good

Access and discharge

- The provider gave us data on bed occupancy from September 2015 to February 2016. The bed occupancy across the service was 93%. Foster ward had average bed occupancy of 81%. O'Connell had an average occupancy of 94%, and Cranford ward operated at an average of 99% bed occupancy. The recommended level is 85%.
- Staff told us that they did not admit new admissions to leave beds. This meant that patients on leave could be assured that if they needed to return to the ward they would still have a bed.
- Staff moved patients between wards only when justified as appropriate on clinical grounds. For example, when patients' mental health had deteriorated and they required more intense support from another ward.
- The provider had a PICU ward on site where wards could access a bed, if required, for a patient who had become increasingly unwell and posed a risk to themselves or others. When the PICU ward did not have available beds, staff transferred patients to other PICU wards run by the provider.
- The provider offered data on delayed discharges from across all their services. This was not broken down into delayed dischargers for singular wards. However, all wards across the older adults service reported that they did not, at the time of inspection, have any patients whose discharge had been delayed.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had a range of rooms available to support the care and treatment of patients. These included examination rooms, quiet rooms, communal lounges, activity rooms and occupational therapy kitchens. Patients could access a swimming pool on site with support from staff.
- O'Connell ward had developed a "pub" for reminiscence. The pub provided patients with non-alcoholic beer and whiskey served by a member of staff. The room contained a large television on the wall for patients to watch films and sport as well as a duke box for music nights. There was also a barber's area in the pub. The hairdresser from the hospital site attended the ward to offer patients haircuts and shaves with hot towels.
- On Cranford ward patients had access to a sensory room. Staff supported patients to use this room for relaxation and as a quiet space when distressed.
- Patients had access to quiet areas on the ward when relatives visited them. There was also a family visiting centre where patients could see family and children.
- Patients were able to access quiet rooms with telephones to contact friends and family. However, on Foster ward the phone was not in a private space, although staff facilitated private calls in patients' bedrooms using the office cordless phone.
- Cranford and Compton wards had direct access to outdoor space. Cranford ward had a secure courtyard area where patients could sit, relax and engage in outdoor games such as football. The provider had redesigned the garden area on Compton to meet the needs of the patients who had a primary diagnosis of dementia. This included soft walk areas to minimise injury from falls, pathways for patients to wander, and a covered seating area. On the day of inspection the ward was having a garden party to celebrate the opening of the new space. Staff arranged attendance of an ice cream van and we observed patients enjoying the garden and the activities.
- Both Foster and O'Connell wards were situated on the first floor, and did not have direct access to outdoor areas. Staff had to support patients to leave the ward if they wanted to access outdoor space. However, this was dependant on staffing levels and availability.

Good

Wards for older people with mental health problems

- On O'Connell ward a roof top terrace was being constructed to provide a new outdoor space and was due to be completed in July 2016.
- Patients had access to food that met nutritional guidelines. However, patients and staff on Cranford ward raised concerns that food was not of good quality or sufficient quantity. Staff complained that staff from other wards were taking additional food allocated for Cranford ward. Staff had reported this to the manager, but had not received any feedback. We fed this back to the manager during the inspection who told us they would investigate the concerns.
- Patients could access drinks and snacks throughout the day and night with the support of staff as they kept the dining areas locked when not in use due to potential risks.
- Patients had personalised their bedrooms when they wanted to. We saw that one patient had brought their own armchair into hospital. Another patient's bedroom displayed posters, and photographs. On O'Connell ward some patients had brought in their own bedding.
- Patients had access to lockable cupboards to securely store their possessions. These were in patients' bedrooms.
- Patients had activity programmes for Monday to Friday which included arts and craft, music groups and access to the occupational therapy kitchens. On O'Connell ward patients had access to an allotment. We observed one of the gardening groups run by occupational therapists and saw that staff encouraged and supported patients to be involved and to do things for themselves. We observed that patients seemed to enjoy this group.
- During the weekends nursing staff provided basic activities such as board games and quizzes.

Meeting the needs of all people who use the service

- Patients who were wheelchair users were able to access O'Connell and Foster wards by a lift. Some bedrooms had ensuite toilets and all doors to rooms were large enough for patients with wheelchairs to access. On O'Connell ward had a provided sensory stimulation with 'tactile wall tiles' (tiles with various textures). They also had a digital fish tank (a television screen displaying moving fish tank scene). We observed that patients with dementia enjoyed watching the fish.
- The provider supplied leaflets in other languages for patients whose first language was not English. Staff had access to patient rights leaflets in different languages and in 'easy read' format. Staff had used an interpreter service to explain to patients their rights when detained under the Mental Health Act, and had translated a care plan and other treatment information into Punjabi.
- Wards displayed information on treatments, local services, patient rights, advocacy, and how to complain. This included the rights of informal patients and their right to leave. Staff displayed activity timetables and menus in communal areas. Staff also displayed the day and date so that people with dementia could be orientated to time and date.
- The provider offered a varied choice of food depending on individual patient need. For example, patients with dementia had access to finger foods throughout the day and those requiring a soft diet had food liquidised into individual separate potions. The provider supported patients with religious and ethnic food requirements.
- Faith rooms were available for patients to use throughout the hospital site. The provider had a chaplaincy service, which attended the wards and met a variety of patients' religious and spiritual needs.

Listening to and learning from concerns and complaints

- The provider gave us data that stated that there had been six complaints relating to older adult inpatient services over the last 12 months, of which the provider upheld three. On O'Connell ward a relative complained a patient's items were unaccounted for and missing. This included gifts and clothing.
- The provider displayed information in communal areas informing patients how to complain. However, some patients had significant memory problems. Staff told us how they supported patients to make a complaint and described the complaints process to us in full.
- The provider sent feedback to all staff on a monthly basis to share lessons learnt form complaints and incidents. Staff were supposed to sign to state they had read the information. However, we found that some staff did not read it, and consequently they were unable to tell us how lessons learnt were shared.

Good

Wards for older people with mental health problems

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

Good

Vision and values

- The provider shared their visions and values with staff through a range of multimedia. This included computer desktop wallpapers and screen savers.
- Team objectives were based around the provider care values so staff were able to relate to the values to practice.
- Staff knew who senior managers within the organisation were. Staff from Cranford, Foster and O'Connell wards told us that senior managers rarely attended the wards. However, on Compton ward staff told us that senior managers had been involved with environment health and safety audits and staff support meetings.

Good governance

- Senior staff had dashboards in place to monitor staff supervisions, mandatory training and appraisals. Staff told us that they received emails from the training department to remind them training was due and it was staffs' responsibility to book themselves onto the required training.
- The provider gave us data on staffing across the older adult inpatient service which demonstrated that there was not always adequate numbers of staff to support patients. For example, ward rotas used by staff, and daily staffing census used by managers to ascertain staff on duty did not correspond with each other. We saw that on one day two staff on Compton ward were detailed on the census as being on duty, yet the ward rotas had not identified them. Consequently, the nurse in charge could not be assured of which staff would be on duty and whether they would have appropriate numbers of staff to meet the needs of patients.
- Unqualified staff were able to maximise time spent with patients on direct care activities. However, qualified nurses told us that they spent much of their time reviewing and updating care plans and risk assessments
- Staff were encouraged to participate in clinical care plan audits.
- Staff did not always follow safeguarding, MHA or MCA procedures. Staff did not always follow up statements that patients lacked capacity with capacity assessments, by recording the reasons for their decision.
- The provider used key performance indicators (KPI's) to gauge the performance of the team. These included staff training, sickness, and incident reporting timeframes. Ward managers told us they were meeting their annual targets and were able to provide us with evidence of this through KPI dashboards.
- Managers told us they had sufficient authority to perform their role and were able to increase staffing levels as required.
- Staff did not know they could submit items of concern to the providers risk register. Some senior staff did not know that such a register existed and therefore had not contributed items to this.

Leadership, morale and staff engagement

- Staff sickness rates among the older adult inpatient services were higher than the national average of 4%. Overall, the services had an average sickness rate of 6%, although Cranford ward had the highest rate at 7%.
- The provider informed us that there was no outstanding or ongoing bullying and harassment cases at the time of inspection.
- Staff knew how to use the whistleblowing process, however told us they had not needed to. We checked our notifications and we had not received a whistle blowing about practice on the wards.
- Staff we spoke with felt they were able to raise concerns as managers had an open door policy and were approachable.
- Staff told us morale was good. Some staff told us they loved their jobs and felt supported within their roles.
- The provider offered opportunities of leadership and development throughout the staff structure. For example, healthcare assistants were able to gain qualifications to support them to access their nursing training. Managers had accessed to management and leadership courses, which helped them to develop their roles.
- Staff were open and transparent when things went wrong. We checked the incident reports and could see that staff informed and supported one patient when a medication error had occurred.

Commitment to quality improvement and innovation

Good

Wards for older people with mental health problems

- The provider participated in national quality improvement programmes and provided us with the key quality improvements for this financial year. We saw that in the older adult inpatient's wards, the goal of ensuring 100% of patients were involved in collaboration and development of their risk assessments was on track. We found evidence that patients were involved in these plans. The provider stated that all physical healthcare outcomes would be recorded on electronic records and we found that this was happening.

Good

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Good

Safe and clean environment

- Staff had clear lines of sight to observe patients on all of the wards.
- The provider carried out regular ligature audits on each ward. The clinical risk manager completed audits every six months, or after maintenance work had been completed. On the ligature risk assessment, staff had not assessed the garden/courtyard area. However, the provider mitigated risks by escorting staff escorted patients at all times through supervised access and individual risk assessments.
- Each ward had a well-equipped clinic room to facilitate physical examinations. Staff checked and recorded clinical fridge temperatures daily. Staff had to share emergency equipment between wards. Wards were locked which could slow response times. However, the provider supplied us with evidence to show they had risk assessed this and located grab bags at key points throughout the hospital. They had carried out drills to show response times were within what was required.
- All wards had a suitable seclusion room, where staff could clearly observe the patient. A clock and intercom allowed patients to talk to staff. Windows on Naseby and Harlestone wards were frosted to ensure privacy.
- All ward areas were clean and well maintained. We saw cleaning rotas for each ward and cleaning staff had a checklist and knew how to order new products. The provider had an up to date infection control policy. A range of infection control posters were displayed which included information around handwashing. Staff could access appropriate personal protective equipment when needed.
- All staff had access to alarms. When activated the alarm pinpointed their location. In addition to this, staff could call for further assistance using a radio. In each patient bedroom, there was a nurse call system so patients could call for assistance.

Safe staffing

- The total number of permanent staff for this core service was 182 of which, 57 were qualified nurses and 125 were nursing assistants. The total number of shifts filled by bureau staff between 1 December 2015 and 29 February 2016 was 5194. Sitwell, Naseby and Mackaness wards had the highest use of bureau staff.
- The provider used regular bureau staff to fill shifts. Permanent staff said bureau staff did not have the same rapport with patients or the same level of responsibilities.
- In the 12 month period of March 2015 to February 2016 the staff sickness rates for permanent staff on Mackaness, Spencer North and Hawkins ward was 4%, Harlestone 3%, Naseby 8%, Sitwell 2%. Ward managers said they were able to book bureau staff to cover sickness or move staff across wards.
- Managers assigned each patient a key worker, which allowed therapeutic relationships to form. Staff told us their caseload was manageable and reviewed frequently.
- Managers said that they rarely cancelled leave or activities due to low staffing. However, some patients said at weekends, activities were cancelled because there was less staff. On two of the wards we visited, staff reported that poor staffing was an issue.

- The hospital had an on-call duty rota to provide medical cover 24 hours a day.
- St Andrew's mandatory training included equality, diversity and human rights training, information governance, safeguarding level one, two and three, basic life support, infection control, managing and preventing violence and how to assess patient risk.

Assessing and managing risk to patients and staff

- Seclusion records for the last six months showed the highest episodes of seclusion were on Sitwell ward, which had 157 episodes of seclusion. The ward with the lowest episodes of seclusion was Harlestone with eight episodes.
- In the last six months, there were high numbers of restraint on Sitwell, with 12 patients being restrained 362 times. On Spencer North 12 patients were restrained 170 times. Prone restraints were used across all wards, these were highest on Sitwell and Spencer North wards.
- Records showed the provider had systems in place for the effective management of violence and aggression. Staff used verbal de-escalation to calm patients. They also encouraged the patient to go to a quiet room if possible. Staff used prevention and management of violence and aggression (PMVA) techniques if de-escalation did not work. Records showed us that staff applied the correct techniques. The provider was rolling out a new restraint training programme, management of actual or potential aggression (MAPA), which focused on using least restrictive practice.
- We looked at 27 patient care records and found staff had completed individualised risk assessments upon admission of the patient. Staff updated these assessments regularly, including at Care Programme Approach (CPA) meetings. Staff told us they put measures in place to mitigate any identified risk. Staff looked at patients' previous history and current behaviours to form a risk plan. The risk assessments were holistic and considered mental health, violence, falls and vulnerability.
- Patients were able to request leave, and their MHA paperwork was checked and signed by senior staff when leave was facilitated.
- We examined records where staff had administered rapid tranquillisation and saw that staff followed the National Institute for Health and Care Excellence (NICE) guidelines.
- We looked at a record of a patient who was secluded. Staff observed the patient regularly and kept detailed notes. Staff gave the patient privacy, access to food and drink and communicated with them regularly.
- All staff were trained in safeguarding and demonstrated a clear understanding of safeguarding procedures. A flowchart was visible on wards, which showed staff how to escalate concerns. The provider had a dedicated safeguarding lead. Managers said that specific training on safeguarding people with learning disabilities or autism was available for staff.
- We looked at 47 patients' prescription charts and medicine administration records. We found that medication was stored securely. There was robust medicines management in place. On Hawkins ward, one prescription chart had a patient signature missing, patients were meant to sign to indicate the medication had been taken.
- The clinical nurse completed a weekly audit on the use of medicines, storage, stock and errors. Staff knew how to contact the pharmacist or senior staff if there were any errors in order to have these corrected promptly. However, on Mackaness ward the clinic room was untidy and the clinical waste bin was full. On Harlestone there was no up to date British National Formulary (BNF). This is a reference book used by staff which contains information about each drug prescribed.
- Each ward had a visiting room that family could use. The hospital had café areas located off the wards for family and patients who could have leave. There were dedicated rooms away from wards for children to visit.

Track record on safety

- From the information the provider supplied, we saw there had been one serious incident on Sitwell ward relating to a patient who self-harmed. There had been two incidents on Spencer North ward relating to mediation errors, and three serious incidents on Naseby ward relating to self-harm and a member of staff being assaulted by a patient.

Reporting incidents and learning from when things go wrong

- Staff we spoke with described the process they followed to report incidents electronically. Staff told us there was a governance process in place to review incidents from across the hospital.

Good

Wards for people with learning disabilities or autism

- Managers investigated incidents and shared outcomes with the teams. However, we looked at five incident records in depth and could not see who had been allocated to some investigations. Not all records had a clear learning plan following an investigation. Staff held weekly discussions around ward incidents and potential risks relating to patients.
- Managers and psychologists offered staff debriefs after every incident. Staff said that debriefs were not always held immediately to allow time for reflection.
- The provider had a shared learning page on the intranet for all staff to read and sent lessons learnt bulletins and red top alerts to all staff.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We looked at 27 care records for patients receiving care and treatment and found staff completed assessments before a patient's admission, and routinely thereafter. Assessments accounted for risks, diagnosis and communication needs.
- The care plans we saw were personalised with pictures of patients' interests, a photograph of the patient and goals and information staff needed. Patients' goals were specific, measurable, achievable, realistic and time bound. Staff used a recovery-planning tool with patients to set goals and review care. Care plans were comprehensive and up to date. However, some care plans were lengthy, which may be difficult for some patients to understand.
- Staff completed and regularly reviewed assessments for patients' physical health needs. Where staff identified a physical health problem, a plan to help manage this was in place. We saw an example of these plans for a patient with diabetes. The plan identified how this would be managed through diet, exercise and medication.
- The provider had an electronic system that stored patients' records and daily notes. Staff recorded patient information securely using this system.

Best practice in treatment and care

- The care records we reviewed showed good practice in the recording of patient contact and contained notes on multidisciplinary team meetings and patient care plan reviews.
- Staff told us, and records showed that National Institute for Health and Care Excellence (NICE) guidelines were followed in relation to patient care. These included the guidelines around epilepsy and the use of psychoactive medicines for people with learning disabilities.
- Psychologists were available to the wards to offer a range of psychosocial interventions based upon the NICE recommended therapies.
- Staff were trained in, and could tell us about, the positive behaviour support approach which was used to encourage patients to recognise good behaviour and skills. Interventions were designed to help patients with coexisting health and mental health problems for challenging behaviour.
- Staff used a range of nationally recognised outcome tools. We saw the use of Health of the Nation Outcome Scales (HoNOS) for people with learning disabilities. Speech and language tools were used to assess and aid communication for patients.
- Managers and ward staff carried out a variety of audits.

Skilled staff to deliver care

- Ward staff included nurses, psychologists, occupational therapists, and psychiatrists. Additional staff who were not based on the ward included speech and language therapists, physiotherapists and dietitians. Staff said they had a good working relationship with other professionals across the hospital.
- All staff completed induction and training. This involved learning about the provider's policies and systems. New staff shadowed experienced staff as part of their training.
- St Andrew's provided data, which showed not all staff had a yearly appraisal. A total of 61% of staff had received an appraisal on Sitwell ward, and 97% of staff on Harlestone ward. Due to the recent employment of new staff, it was likely that certain staff members would not have been in employment long enough to receive an appraisal.
- Managers gave staff supervision monthly. Staff said they could discuss patient cases at any time during team meetings.
- Staff attended daily handovers and team meetings and felt they could discuss patient need.

Good

Wards for people with learning disabilities or autism

- Ward managers addressed staff performance and issues promptly. Where staff were suspended pending an investigation, this was done efficiently and in line with provider's policy.

Multi-disciplinary and inter-agency team work

- Each ward manager held a weekly multidisciplinary team meeting, all staff on duty attended from all different disciplines.
- Staff said they found it easy to approach doctors and psychologists for advice and support at any time.
- Ward managers and staff held handover meetings at the start of each shift and at the end of the day. We saw staff discussed patient risks, behaviours and any incidents. Staff working over more than one ward planned these meetings so that they could attend as many as possible for each ward.

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

- The provider supplied mandatory Mental Health Act (MHA) to staff. Training records showed staff completed this as online learning within one month of their induction. A total of 82% of all new staff had completed training since June 2015 across the hospital.
- Out of 42 members of staff we spoke with, 36 could describe the basic principles of the MHA and demonstrated knowledge of the code of practice. Staff said they felt confident to ask their manager for further advice if needed.
- Five members of staff said they had not received further training in the MHA since their induction, and were unaware of further training or updates.
- We saw each ward had an up to date MHA code of practice and staff had access to the provider's MHA policy, as well as a MHA administration team.
- Records showed patients had their rights explained to them regularly; staff recorded in case notes if a patient did not understand their rights, and redelivered or explained them in a different format.
- Managers and nursing staff regularly audited patients' detention paperwork.
- Patients across the hospital could access the Independent Mental Health Advocacy (IMHA) service.

Good practice in applying the Mental Capacity Act

- Staff received mandatory Mental Capacity Act (MCA) training upon induction.
- When we spoke with staff, they demonstrated good knowledge of MCA and Deprivation of Liberty and Safeguards (DoLS).
- Staff had made no DoLS applications for patients on the wards we visited. Staff knew how and where to access the relevant policies around DoLS.
- Staff assessed patients' capacity to consent to treatment and care on a regular basis. We saw examples in care notes of specific capacity assessments taking place.
- Some staff lacked confidence in the application of the MCA. However, senior ward staff and some nurses were confident in completing paperwork and offering advice.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- We observed staff treating patients with respect, care and compassion. Patients knew staff by name, including cleaning and maintenance staff.
- We saw staff having meaningful discussions about patients' wellbeing.
- One cleaner described to us how she planned her day around patients, as one patient was distressed when hoovering needed to be done, the cleaner went out of her way to ensure the patient was away or off ward during this duty.
- Staff had a good understanding of the personal likes and dislikes of patients. They knew what religious practices patients wished to engage in. We saw staff ensured patients' needs and likes were met by offering activities of interest.
- Patients told us some staff were very nice and caring, they felt involved in decisions about their treatment and found it fun when staff joined in with their activity.
- Patients said staff worked hard and seemed to like their job.

The involvement of people in the care they receive

Good

Wards for people with learning disabilities or autism

- Care records showed that staff assessed patients before admission to hospital. Patients had been involved in the planning of their care and treatment and signed care plans to indicate this. Staff offered patients copies of their care plans.
- Care plans documented individual patient's interests and needs. On Hawkins ward, we observed a care plan assessment multidisciplinary (MDT) meeting. Family members were invited to attend and solicitor when needed. The agenda was holistic and allowed the patient to identify how they were progressing, what future goals and next steps they would take and everyone gave feedback. We saw comprehensive notes in patients' care records.
- In MDT meetings, staff discussed patient's discharge plans, therapies and activities. The patient had time to raise any concerns and suggest treatment options.
- Each ward held community meetings for patients and staff to attend. We saw meeting minutes that showed patients and staff had discussions around wellbeing, the community on the ward, upcoming activities and covered feedback from incidents.
- Carers we spoke with said staff were helpful and positive about patients. One carer said they were given a room to stay in overnight so they could attend their relative's care plan review.

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

(for example, to feedback?)

Good

Access and discharge

- Patients followed the learning disabilities pathway through services. Staff told us there was a waiting list for some of the wards. Some wards were not taking additional patients in due to complex needs and lack of space. Bed occupancy was between 86% for Spencer North and 100% for Harlestone. The recommended level is 85%.
- Staff assessed patients prior to admission, and this process could take two to three weeks and the waiting time from assessment to treatment could take a further two weeks.
- Beds were available for patients living locally, however many patients originated from areas outside of Northampton. Staff were able to prioritise assessments based on need.
- Average length of stay within this division was five years.
- Patients who went out on leave were able to return to the same bedroom.
- We reviewed two patients' records who had moved ward since admission. We found managers and clinical staff made these decisions based on the needs of the patient and their safety.

The facilities promote recovery, comfort, dignity and confidentiality

- A range of rooms was available to facilitate one to one time between staff and patients. On all wards, there was a large activity room with a game area, television and comfortable seating. There were quiet rooms for patient to use when the wished. All wards had a sensory room that patients could access with staff.
- Activities took place during the week and weekends. Wards had a range of facilities to promote comfort and recovery. Patients had a choice of activities. We saw where patients had planted some flowers.
- Staff held cookery sessions for patients in ward kitchens. Patients told us they could cook if they wanted with staff supervision. Staff said they wanted to be able to deliver cookery qualifications such as food and hygiene for patients. However, the provider told us that patients were able to complete food hygiene qualifications and other cookery related training. We saw this on our visit to a workshop.
- On each ward, patients could use a pay phone to hold private calls.
- Patients had posters and their names up on doors. They were also able to personalise their rooms. Patients were given lockers to store personal belongings securely.
- Patients could have drinks on request, on some wards staff made a jug of juice for patients to help themselves. Staff served drinks throughout the day.

Meeting the needs of all people who use the service

- All wards were wheelchair user friendly. Some wards were situated on the ground floor, which opened onto the garden for easy access.
- Information and leaflets were written in English, staff told us they gave patients a translated leaflet or used translation services if needed.

Good

Wards for people with learning disabilities or autism

- On Harlestone ward, staff put up daily weather forecasts to help patients plan what to wear if going outside.
- Patients had a choice of food, cooked on site and which met patients' nutritional and dietary requirements. We visited during the Ramadan fasting and saw that staff had supported a patient who wished to fast during the day.

Listening to and learning from concerns and complaints

- The provider supplied us with complaints for a 12-month period. Hawkins and Naseby ward had no complaints; Harlestone had 12, five of which were upheld, Mackaness had 19, of which three were upheld, Spencer North two, none was upheld and Sitwell 29 where seven were upheld.
- Information about the complaints and feedback process was in easy read format. Patients told us they could speed dial the complaint service. Patients and carers we spoke with knew how to make a complaint. Ward managers told us they shared learning from complaints among staff and via emails.
- Managers told us in the first instance, they would try to resolve the complaint at ward level. If this required escalation, they would follow the provider's complaint policy. We saw a letter from the provider's chief executive, apologising to a patient for activities that were cancelled owing to low staffing.

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

Good

Vision and values

- Staff were aware of the provider's visions and values. We were told these were available on the intranet. We saw the provider's values were displayed on walls for patients to read.
- Staff were able to tell us who their senior managers were, but felt that the senior management team were not visible.

Good governance

- A variety of training was provided. Psychology staff told us they had organised some specific training for staff relating to learning disabilities.
- Staff had access to regular supervision. The provider's policy encouraged staff to seek clinical supervision when needed. All records we looked at showed that supervision had taken place. However, there were inconsistencies across all wards as notes did not show us if staff had any development objectives or if individual patient cases were discussed.
- During morning meetings we saw that daily tasks and activities were planned to increase patient contact and limit administrative tasks.
- Evidence showed the provider carried out clinical and non-clinical audits. They had infection control leads who monitored infection control and clinical waste disposal. Lead psychiatrists audited the psychotropic prescribing in the autism spectrum pathway. Ward managers audited patient care plans and risk assessments. Some staff said they participated in audits such as a ward hygiene audit.
- There was an effective incident reporting and monitoring system in place.
- Ward managers said they had sufficient authority to manager their wards, and received support from their manager.

Leadership, morale and staff engagement

- Staff were aware of the provider's whistleblowing policy. They told us what actions they would take if they had any concerns.
- Staff told us they liked their job and working with patients. They said in general morale is good, but in the past, if wards were short staffed they had felt pressured.
- Staff said they felt supported by their managers and encouraged to share knowledge.
- Some of the doctors we spoke with said they were unsure about future hours and felt they were not supported by the provider to refresh their training or develop new skills.

Commitment to quality improvement and innovation

- The provider participated in the Quality Network for Inpatient Disabilities Services. This provided a system for staff to share good practice and peer review work.
- The psychologists in the learning disability and autism pathway were active in researching and publishing effective interventions. Psychologists we spoke with

explained they had developed key interventions that related to the needs of their patients. For example, learning to manage anger and develop skills for coping when distressed, muscle relaxation for women and crisis management. Psychosocial treatment for posttraumatic stress disorder was available on site.

Good

Services for people with acquired brain injury

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

Are services for people with acquired brain injury safe?

Good

Safe and clean environment

- The layout of the wards meant observation of patients was not possible from all areas. The provider had identified and reduced the risk of blind spots by installing mirrors and increasing observation levels. The needs of the patient group reduced much of the risk associated with self-harm.
- Each ward had a comprehensive, up to date and weighted ligature risk audit in place. Ligature points are fittings to which patients intent on self-injury might tie something to harm themselves. The provider mitigated these risks by increasing observation levels when needed. The provider had rooms that were 'no ligature' for use of patients expressing or assessed as at risk of potential self-harm. Staff had completed environmental risk assessments that were comprehensive and up to date.
- The provider met the Department of Health guidance on eliminating mixed sex accommodation. Most patient bedrooms had ensuite toilets, and or showers and washbasins. All ward bedrooms had viewing panels to aid staff observations. The bedrooms on Berkeley Lodge and the individual residences did not have viewing panels or ensuites.
- There were clinic rooms on each ward with accessible resuscitation equipment. Staff regularly checked equipment and records were in date. The clinic room on Althorp ward was small but staff said this met their needs.
- The seclusion facilities on site met the required standards along with 'extra care' suites where patients who needed further support would receive this.
- Wards were clean and had well-maintained furnishings. The provider had up to date cleaning records. Refurbishment was taking place on Althorp ward.
- All staff carried personal alarms. Patients had call bells in their bedrooms to summon assistance when needed.

Safe staffing

- The ward manager could adjust staffing levels when required to meet the needs of patients, following discussion with senior management. We saw examples of when this had happened. Qualified nurses were available in communal areas of the ward at all times. There was one qualified member of staff managing the four community based rehabilitation houses. However, patients and this staff member were also supported by the nurse manager and the main Berkeley Close multidisciplinary team.
- Regular bureau and agency staff were used to cover any gaps in staffing. Bank staff were known as 'bureau' staff and were employees of the provider who worked extra shifts. This ensured that the patients knew staff wherever possible.
- The provider had used bureau or agency staff to cover 2573 shifts in the past three months and had been unable to fill 1211 shifts, which was 47%. Unfilled shifts were due to unplanned absences, for example sickness.

Good

Services for people with acquired brain injury

- Over recruitment was taking place to support the neuro psychiatric pathway. This meant there was enough staff to deliver safe care and treatment.
- Staffing information showed us there was enough staff to deliver safe care. However, some staff told us that wards were left short staffed at times when staff were moved to work on other wards to cover shortfalls.
- Data provided indicated a staff sickness rate of 3.3% over the past twelve months. This was below the national average. There were 19 staff leavers. The majority of these were due to professional development and competition from other providers.
- All staff were required to complete mandatory training as identified by the provider. The provider monitored compliance via their training and development team. The average compliance on the neuro psychiatric wards was 100%.
- Staff knew how to access out of hours medical cover.

Assessing and managing risk to patients and staff

- Tavener and Rose ward had a seclusion suite. There were 20 reported incidents of patients requiring seclusion or long-term segregation in the last six months.
- Staff practiced verbal de-escalation and distraction techniques with good effect. Staff used physical restraint as a last resort and rapid tranquilisation very rarely. There were 365 incidents of physical restraint in the last six months. Fifty-two incidents of physical restraint resulted in patients placed in the prone (face down) position. Medical staff reviewed patients, subject to restraint, in a timely manner and in accordance with the revised MHA Code of Practice. We reviewed recent records of restraint episodes. Staff had completed them appropriately.
- The provider had policies and procedures for the use of enhanced patient observation. Good records were in place to support this practice. Clear policies and procedures were in place for conducting room searches and searching patients upon return from leave based on individual risks. The provider had procedures in place to review and record this.
- Senior staff had procedures for keeping staff safe. These included the use of key management systems, alarms, training and development, support, access to 'care first' external staff support systems and occupational health support.
- Senior staff told us that they escalated concerns to the executive team and service director. These were usually addressed promptly. The regional senior management team and governance meetings monitored risk assessments for the hospital. Information was available through 'red top alerts' and viewed at monthly service manager meetings.
- All staff had received mandatory safeguarding training. Staff knew when and how to appropriately escalate any concerns. Guidance was available on each ward along with nominated safeguarding leads.
- We reviewed 14 medication charts in detail. The provider used a comprehensive prescription and medication administration chart. This facilitated the safe prescribing and administration of medicines. Doctors and pharmacists regularly reviewed prescriptions, and records of administration were fully completed.
- Pharmacy services attended the wards regularly to ensure medicine was available when needed. Pharmacy audits were regularly undertaken. When concerns were identified, we saw evidence of actions being completed to address these.
- Controlled drugs were stored securely and recorded in the register. On one ward the controlled drugs records were incorrect, this was brought to the attention of senior managers who investigated immediately and resolved the matter.
- The provider had a policy to manage children visiting the service, there were designated visiting rooms to ensure privacy and safety.

Track record on safety

- The provider reported 11 serious incidents in the preceding 12 months. Incidents reported included patients absconding, patient attempts to self-harm, alleged staff to patient assault, staff injury, patient injury. The provider had investigated these incidents appropriately.

Reporting incidents and learning from when things go wrong

- Staff recognised and reported incidents. The provider had electronic systems in place that included prompts to ensure that staff recorded all information about the incident.

Good

Services for people with acquired brain injury

- Staff demonstrated a good understanding of what they should do when things go wrong in line with the principles of the 'duty of candour' and letting patients know when things had gone wrong.
- Staff received feedback from investigations of incidents. Managers shared learning with their teams. Senior management cascaded information via the 'red top' email alerts to make sure all staff were informed of learning.
- Staff took steps to improve safety following incidents. For example, staff secured patio furniture to the floor following a patient attempt to scale a wall.
- Some staff said that following incidents there was little support offered in the form of debriefing. The inspector brought this to the attention of managers at the time of the inspection.

Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed the care and treatment records of 24 patients. We found a comprehensive and timely assessment of individual needs.
- Care records showed there was ongoing assessment and monitoring of physical healthcare needs. All patients received physical health checks within 48 hours of admission and subsequently based on individual need. Practice nurses from the on-site GP surgery provided physical health care support to patients on the wards.
- Care plans were comprehensive and holistic, and contained a full description of needs and problems. Staff highlighted risk and created individual risk assessments that linked into care plans. Staff had created care plans in line with the National Institute for Health and Care Excellence (NICE) guidelines. Some patients had copies in their bedrooms.
- Confidential patient information was stored securely within electronic records that were accessible to staff across the site. These were password protected and access controlled.

Best practice in treatment and care

- Medication prescribing was in accordance with National Institute for Health and Care Excellence (NICE) guidelines and within British National Formulary (BNF) limits for safe prescribing.
- Staff carried out routine physical observations. The practice nurses attached to the on-site GP surgery were available to contact for advice about minor physical health care needs. GPs were available for support. Staff made referrals for specialist neurological input when needed. We saw records of healthcare screening appointments, including dental and podiatry care. Care plans were in place to support patients with ongoing healthcare needs.
- Patients were encouraged to participate in healthy lifestyles, including walking groups, attending the gym and healthy eating. There was an initiative to encourage patients and staff to 'get walking'.
- Staff used outcome measures such as health of the nation outcome scale (HoNOS) and specific tools to monitor and assess the progress of patients. These included the St Andrew's Swansea neurobehavioral outcomes scale, the St Andrew's sexual behaviour assessment scale, the overt aggression scale modified for neuro-rehabilitation, the functional independence measure and the functional assessment measure.
- Staff participated in clinical audits covering patient observations, self-harm, mattresses, care programme approach (CPA) and the Mental Capacity Act 2005 (MCA).

Skilled staff to deliver care

- The multidisciplinary team within this service provided patients with access to a variety of skilled and experienced practitioners who together with the patient could create person centred, individualised care and treatment. Staff from neuropsychology, psychology, occupational therapy, psychiatry, speech and language therapy, physiotherapy, social worker, nursing and rehabilitation made up the multidisciplinary teams.
- Staff were suitably qualified for their role and encouraged to participate in professional development.
- New staff had a full induction programme they completed prior to working full time on the wards.
- Rehabilitation workers could train for the care certificate. This qualification provides health and social care support workers with the knowledge and skills needed to deliver safe and compassionate care.

Good

Services for people with acquired brain injury

- Staff told us specialist training was available. There was protected time on the wards each week for whole team learning led by specialists if required. Staff told us the provider supported them to undertake training and gain extra qualifications.
- Staff attended team meetings. Ward managers ensured that team objectives were regularly discussed and outcomes reviewed by attending team meetings with both day and night staff. Staff recorded minutes of the meetings for future use and referral.

Multi-disciplinary and inter-agency team work

- Staff attended handover meetings at the beginning of each shift to obtain updates on patients' care.
- Staff held regular meetings including patient referral, admission and discharge meetings, ward team meetings, community meetings and staff and patient link up meetings. We saw appropriately recorded minutes with identified actions.
- Staff worked with external agencies, such as commissioners, community mental health teams, ministry of justice and local authorities. This included liaison with multi-agency public protection arrangements. This ensured a proactive approach to the co-ordinated care of patients.

Adherence to the MHA and the MHA Code of Practice

- At the time of the inspection there were 68 patients detained under the Mental Health Act 1983 (MHA) receiving care and treatment on the neuro psychiatric pathway.
- All staff had received training in the MHA and code of practice as part of their induction.
- Staff uploaded detention papers onto the electronic records system. Staff had completed these in full and appeared to be in order.
- Staff discussed patients' rights under Section 132 of the MHA every month with the patient. This discussion included information on the role of independent mental health advocates (IMHA). Information about IMHA services was included in the patients' portfolios and on display on the ward. IMHAs attended clinical reviews and other meetings on request from patients.
- Patients who were subject to the MHA and were receiving medication had consent to treatment or appropriate second opinion approved doctor forms completed. Treatment forms were available for checking when administering medication. This meant that staff could be sure that medication administration was in accordance with the MHA for detained patients.
- Staff knew how to contact the Mental Health Act team for advice. There was an effective system for checking MHA documentation.
- The responsible clinicians were available to provide medical cover as required by the revised code of practice dated 2015.

Good practice in applying the MCA

- The provider had a policy on the Mental Capacity Act (MCA) and a Mental Health Act team were available to support staff with any queries. Appropriate MCA assessments, to establish capacity to consent to care and treatment of informal patients, were completed. The provider took appropriate action to safeguard the rights of these patients.
- There were five patients subject to Deprivation of Liberty Safeguards (DoLS) receiving care and treatment in the service.
- Each member of staff had received training in the Mental Capacity Act 2005 (MCA). Staff had good understanding of the five statutory principals of the MCA. Staff told us how they used it in their role.
- Patients had access to independent mental capacity advocate (IMCA) services when needed.

Are services for people with acquired brain injury caring?

Good

Kindness, dignity, respect and support

- Patients told us that staff were supportive and kind to them.
- We observed good interactions between patients and staff. We saw staff were friendly and respectful when speaking with patients. Staff responded quickly to requests for assistance.
- Staff were passionate and enthusiastic about providing care to patients with complex needs. They explained to us how they delivered care to individual patients. They demonstrated a good understanding of the specific care and treatment needs of their patients.

Good

Services for people with acquired brain injury

The involvement of people in the care they receive

- Patients' involvement in care planning was variable. Not all plans contained patients' comments and whilst some included notes stating the patient was unable to comment, it was not always clear what steps the provider had taken to involve them. Some patients had copies of their care plans.
- Patients, who were able to, discussed concerns and were involved in decisions at regular ward based community meetings.
- Some patients were involved in recruitment and induction of new staff.
- We found that family and carers were involved where appropriate, in the assessment process and in individual care review meetings.

Are services for people with acquired brain injury responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- The wards bed occupancy over the past six months was between 98% and 82% over the past year. The patient group was stable and on rehabilitation pathways that took time to complete.
- Care pathways and admissions were from ward to ward along the care pathway or from external referrals in the initial referral stage. The provider admitted patients from various parts of the United Kingdom if specialist services were not available in their local area to meet their need.
- The provider told us that admissions and discharges were sometimes delayed due to complex funding arrangements. The length of stay varied and some patients were on restrictive sections of the Mental Health Act. There were no delayed discharges over the past 12 months.
- The provider had their own rehabilitation houses where patients could transfer to continue their recovery in a community setting.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital had a range of rooms for delivering care and treatment. These included clinic rooms, on site GP surgery, dentist, and facilities for examining patients. Computers for patient use were available in some wards. There was a church in the grounds.
- Patients were able to personalise their rooms. Patients' artwork decorated the communal areas and corridors of the wards. Quiet areas were available on the wards and we saw rooms where patients could meet visitors in private.
- Patients had their own mobile phones based on individual risk assessments and had access to a telephone and could make calls in private.
- Patients could access cold drinks at any time and could request hot drinks. Patients had agreed access to snacks dependent on their care plans.
- The provider was redecorating Althorp ward and there were ongoing refurbishment plans for other wards.

Meeting the needs of all people who use the service

- There were aids and adaptions for patients with mobility difficulties or at risk of falls. There were disabled bathrooms with hoists, showers and specialised assisted baths.
- Patients had information packs that included information about the service, advocacy details, the role of the Care Quality Commission and other relevant information in their bedrooms as well as displayed on notice boards.
- The chef and catering team cooked fresh food, which was delivered daily to the wards. Food was modified to each patient's individual requirements in a specialist diets kitchen.
- The provider identified spiritual needs during the pre-admission process. Patients could visit local churches and other places of worship where possible. Staff arranged for faith leaders to come to the wards when patients requested. However, there were no multi-faith room facilities on site.

Listening to and learning from concerns and complaints

- Patients had made 34 complaints to the provider in the past 12 months. The provider upheld 10 of these. No complaints had been forwarded to the Independent Sector Complaints Adjudication Service (ISCAS).
- Evidence was seen of changes having been made to practice following upheld complaints.

Good

Services for people with acquired brain injury

- Staff linked complaints to safeguarding processes where appropriate.
- Patients could raise concerns with staff and managers. Staff knew how to support patients and carers to make complaints formally.

Are services for people with acquired brain injury well-led?

Good

Vision and values

- Staff identified with the values of the organisation. Staff understood how the values linked to practice.
- Staff told us senior managers were approachable and they regularly visited their ward. We saw this during the inspection and observed patients were familiar with senior managers when they visited the ward.
- However, some staff told us the executive team were remote and did not visit wards.

Good governance

- The hospital had a clear clinical governance structure. Clinical front line staff carried out audits at ward level. Staff used the results to improve practice.
- One hundred percent of staff were compliant with mandatory training, against a hospital target of 95%. Staff had received monthly supervision and an annual appraisal.
- Systems were in place for reporting and learning from incidents. These were cascaded via email and discussed at governance and ward meetings.
- Managers had access to dashboards that tracked incidents and other relevant data for their wards. Managers contributed to the 'ward to board' tool used by the provider. Senior managers used these to monitor quality across the larger hospital site.
- Systems were in place to monitor compliance with the Mental Health Act 1983 and Mental Capacity Act 2005.

Leadership, morale and staff engagement

- There were no incidents of bullying and harassment reported. The hospital had a whistleblowing policy. This was available to all staff and they knew how to follow it.
- Staff told us they felt supported to raise concerns without fear of victimisation and their line manager was understanding, supportive and approachable.
- Staff told us they enjoyed working in the neuro psychiatric pathway and that morale overall was good. Many staff had worked within the larger hospital for a number of years. Staff reported good multi-disciplinary and ward team working. There was a support group for newly qualified nurses.

Commitment to quality improvement and innovation

- The psychology team was heavily involved in new programmes and initiatives, that included patient led elements in order to continue to improve the treatment outcomes for patients.
- The hospital had systems in place to improve the care and treatment provided to patients. For example, joint staff training sessions with the Huntingdon's disease association.
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Outstanding practice and areas for improvement

Outstanding practice

Forensic wards had yellow emergency boxes in various locations around the clinical area. These boxes contained ligature cutters and pocket masks (for use in mouth to mouth resuscitation) for staff use in emergencies. The provider had considered the size of the ward and the time it would take to access equipment in the event of an emergency when locating these boxes. Staff being able to quickly access emergency equipment, such as ligature cutters, is both practically sensible and potentially lifesaving.

The provider had carefully planned the extra care suite on Stowe ward. We were particularly impressed with the safety surface in the private courtyard, which reduced the risk of injury to patients and staff. We were informed that this surface is present throughout all seclusion courtyards.

Patients followed a recruitment process and were able to gain work experience in a variety of work settings on site.

Accommodation was available for relatives through the family visiting facility, which was accessible to all Northampton based pathways.

We saw the documents to show, the provider was offering an 'Aspire campaign', which supported healthcare support workers to undertake their nurse training. The provider would pay these staff a bursary to support their training, following which they would return to work at St Andrew's for a minimum of two further years. The provider had plans to support 20 staff a year in this scheme.

Areas for improvement

Action the provider MUST take to improve

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

Action the provider SHOULD take to improve

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

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 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10** Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect: • The provider had not ensured the dignity and respect of patients was protected during seclusion. • On PICU patients when showering were unable to lock the door, as other patients may need access to use the toilet. Some shower cubicles did not have curtains. • Searches were sometimes carried out in communal areas. This was a breach of regulation 10(1)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11** Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent • Staff documented that patient did not have capacity to consent to treatment but did not give a rationale as to why they were unable to consent. Mental capacity assessments were not decision specific. This was a breach of regulation 11 (1)

This section is primarily information for the provider

Requirement notices

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 **Regulation 12** Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment: • The provider had not ensured that staff completed and recorded appropriate physical checks for patients in seclusion and following rapid tranquilisation and understood when they needed to escalate concerns. • There were ligature points within the PICU. There were no individual contingency plans and arrangements in place to mitigate the risks to people who use the service. Care plans did not reflect any mitigation. This was a breach of regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Regulation 14** Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The nutritional and hydration needs of services users must be met. • The provider had not ensured that staff adequately recorded the diet and fluid needs of patients in seclusion and in rehabilitation services. This was a breach of regulation 14(1)(2)(b)(4)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15** Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment: • The provider had not ensured the air exchange system on Seacole ward was working efficiently, for the comfort of patients and staff. This was a breach of regulation 15 (1)(e)
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 **Regulation 18** Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing: • The provider did not always ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the service. • Some staff did not receive appropriate ongoing or periodic management supervision in their role to make sure they maintain their competence. This was a breach of regulation 18(1)(2)(a)