St Andrew's Healthcare - Essex

Quality Report

St Andrew's Healthcare
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North Benfleet
Essex
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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?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

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

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

Summary of findings

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 Essex as 'requires improvement' because:

- The provider had not included all ligature points in their ligature risk assessments.
- Staff did not always record or manage seclusion and long term segregation in accordance with requirements of the Mental Health Act (MHA) code of practice.
- The provider had limited rooms or quiet areas on some wards for care and treatment. Staff regularly transferred patients between wards in order to access safe areas to manage disturbed behaviour. Staff transferred patients between wards via lifts or staircases during periods of agitation. This was a risk to patients and staff.
- Wards had limited space for patients to meet visitors in private.
- There was a delay in replacing curtain rails and other repairs on wards, affecting patients' privacy and dignity.
- Staff had not fully completed an evacuation care plan for a disabled patient and the required evacuation chair, for use in an emergency, was not available.
- Medication management/prescribing was not always reviewed in a timely manner.
- Staff were not always aware where to find information in electronic patient records. This meant there may be a delay in finding up to date information.
- The provider had discrepancies in their staff rotas. Records did not always accurately reflect the staffing on duty.
- The provider did not have consistent records of management supervision. Management supervision records were inconsistent and poorly documented.
- Some staff had reported experiencing racial abuse and felt that managers had not responded appropriately to their concerns. However, the provider was able to demonstrate issues of racial abuse were investigated. The provider supplied data that showed from 01 April to 21 September 2016, there were seven recorded accounts of verbal racial abuse. The data also showed that managers addressed incidents at a local level in discussion with staff, with peer support and through reflective meetings. Staff were encouraged to report these incidents to the police. The provider's workforce race equality standard (WRES) action plan provided showed the provider monitored incidents of verbal abuse of staff through the electronic reporting system.

However:

- Patients spoke positively about staff and told us they felt safe on the ward and staff were available to support them. We saw good rapport between staff and patients, positive staff and patient interaction and individual support.
- The provider supplied specific 'yellow boxes' for staff use in an emergency, for example, ligature cutters. This ensured staff could respond quickly to patients in an emergency.
- The provider operated a 'safewards' initiative on Hadleigh Ward. We saw this had a positive impact on patient care.
- Staff were aware of their individual responsibility in identifying safeguarding concerns and reporting these promptly.
- Staff kept accurate and detailed patient records. Care plans were detailed and showed both patient and multidisciplinary team (MDT) involvement.
- There was effective MDT working. Patients had opportunities to get involved in hospital governance for example in the monthly patients' forum.
- Cleaning records were up to date and we saw evidence that regular cleaning and audits were taking place.

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** 	Audley ward is a 12 bed male psychiatric intensive care unit. Frinton ward is a 12 bed female psychiatric intensive care unit
Forensic inpatient/ secure wards	**Requires improvement** 	Danbury ward is an 18 bed low secure service for men. Hadleigh ward is a 16 bed low secure service for men. Maldon ward is a 6 bed low secure service for women. Colne ward is a 16 bed low secure service for women.

Summary of findings

Contents

Requires improvement

St Andrew's Healthcare - Essex

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards

Summary of this inspection

Background to St Andrew's Healthcare - Essex

St Andrew's Essex is a low secure hospital situated in North Benfleet, Essex and has been registered with the CQC since 11 April 2011.

The services have a registered manager and a controlled drugs accountable officer. The registered location at Essex provides men's services and women's services including psychiatric intensive care units and forensic inpatient/secure wards. The hospital is currently registered to accommodate 92 adults who have mental illness and can be detained under the Mental Health Act 1983. St Andrew's Essex consists of six wards and currently has 82 beds. We inspected all wards during this inspection.

Danbury ward has 18 beds and Hadleigh ward has 16 beds; they provide low secure services for men. Maldon ward has six beds and Colne ward has 16 beds; they provide low secure services for women. Audley ward has 12 beds and provides psychiatric intensive care (PICU) for men. Frinton ward has 12 beds and provides psychiatric intensive care (PICU) for women.

Maldon ward had an unannounced focused inspection on 31 March 2016 due to concerns raised to CQC. These concerns included: safe staffing levels, particularly at night, standards of care provided to patients due to high use of agency staff, concerns that doctors were not always attending the unit to support patients in seclusion in accordance with the Mental Health Act 1983 code of practice. The outcome of which was requirement notices for:

- The provider must ensure sufficient staff cover to maintain the safety of the patients. Staff rotas must accurately reflect the staff on duty in order for shifts to be planned safely and for the provider and staff to be accountable for treatment delivered. This was a breach of regulation 18 (1).
- The provider did not ensure risk to patients were assessed, reviewed and updated regularly. This was a breach of regulation 12 (1)(2)(a)(b).
- The provider must ensure that agency staff have access to appropriate information about patients to provide compassionate, safe care. This was a breach of regulation 17(2)(c-d).
- The provider should ensure that resuscitation equipment could be obtained on all wards in an appropriate time frame.

Our inspection team

The team that inspected the service comprised team leader: Margaret Eaves-Fletton, inspector mental health hospitals, CQC.

The team that inspected the location consisted of three inspection managers, three inspectors, one Mental Health Act reviewer, one consultant psychiatrist special advisor and one advisor who has experience of using, or caring for someone, who uses services.

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive mental health inspection programme.

Summary of this inspection

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, and asked stakeholders for information.

Maldon ward had an unannounced focused inspection on 31 March 2016 due to concerns raised to CQC.

During the inspection visit, the inspection team:

- visited six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 25 patients who were receiving care and treatment;
- spoke with one carer of a patient who was receiving care and treatment;
- spoke with 36 individual staff members including doctors nurses, occupational therapists, psychologists, pharmacists, clinical information assistants and social workers.
- facilitated four focus groups with 23 staff members and one drop in with two staff members;
- spoke with all ward managers;
- spoke with the registered manager, operations manager, Mental Health Act case manager, safeguarding lead, health and safety manager, training lead and HR business partner;
- observed one care plan update meeting, one patient community meeting;
- collected feedback from 35 patients using comment cards;
- looked at 25 care and treatment records of patients;
- carried out a specific check of the medication management on all wards, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

We returned to St Andrew's Essex for a follow-up unannounced inspection on 4 October 2016.

What people who use the service say

- Most patients told us of different ways in which the hospital staff encouraged their involvement in their care and treatment: Twenty-four said they felt respected, five said they received a good service and 20 said the staff were caring.
- One patient told us they had not received acknowledgement of complaints made and two said they did not feel confident to complain.
- Most patients said there was a lack of privacy for visits. Three patients told us they needed more activities as these were only Monday to Friday and there was not much to do at weekends. A further three said they would like the internet available at weekends. They felt if they were able to use the internet this would prevent them becoming bored. Two patients said they felt unsafe when staff could not restrain other patients when they became aggressive. Patients on one ward told us the food was not good, and one felt that their cultural dietary needs were not being met.
- Patients told us some staff did not knock before entering their room, that staff were not always visible and one patient said their escorted ground leave was often cancelled due to low staffing.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated St Andrew's Essex as **'requires improvement'** because:

- The provider had not included all ligature risks in their ligature risk audit.
- Staff did not always manage or record when patients were subject to seclusion and segregation in line with the safeguards set out in the Mental Health Act Code of Practice.
- Staffing rotas were not accurate and some shifts were unfilled.
- Medication management/prescribing was not always reviewed in a timely manner.

However:

- Most patients told us they felt safe on the ward and were able to tell staff if they had any concerns.
- Staff knew how and where to access ligature cutters. The provider had designated 'yellow boxes' in clinical areas for staff to access emergency equipment, including ligature cutters quickly.
- Staff were aware of their individual responsibility in identifying any individual safeguarding concerns and reporting these promptly.
- The provider used nationally recognised risk assessments such as threshold assessment grid.
- We were shown the 'safewards' initiative and its positive effects on patient care.
- The provider had established a project group to identify what actions needed to be taken to be compliant with the duty of candour regulation.
- Cleaning records were up to date and we saw evidence that regular cleaning and audits were taking place.

Are services effective?

Requires improvement

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

- The provider did not have an effective management supervision structure. Records were inconsistent and poorly documented. This meant they were not demonstrating how performance issues were managed. There was no data made available to show management supervision rates achieved.
- Staff were not always aware where to find information in electronic patient records.
- The provider's compliance with staff appraisals for Hadleigh ward at 64% did not met the provider's policy.

Summary of this inspection

However:

- The provider supplied clinical supervision data that showed most staff were in receipt.
- Most staff on five of the six wards had received an annual appraisal.
- The provider had a robust multidisciplinary team who worked well together for the benefit of patients.
- The provider used the nationally recognised outcome measure Health of the Nation Outcome Scales.
- The provider had effective processes for the management and recording of Mental Health Act paperwork

Are services caring?

Good

We rated caring as **good** because:

- We saw good rapport between staff and patients.
- Patients gave us positive feedback about staff.
- Patients had opportunities to get involved in hospital governance for example in the monthly patients' forum.
- Patients chaired the weekly community meeting across all wards.
- We saw positive staff and patient interaction and individual support.
- Staff completed detailed care plans that showed patient involvement.
- Where appropriate, staff ensured patients' families and carers were involved in their care.

Are services responsive?

Requires improvement

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

- The provider was updating curtain rails across all wards. However, patients had been left without curtains at some bedroom windows whilst this work was being undertaken. This was detrimental to their privacy and dignity.
- Some wards had a lack of rooms available for care and treatment.
- Patients told us they would like access to computers over weekends.
- The evac-chair on one ward, for use in an emergency evacuation was not there.
- Staff had not fully completed an evacuation care plan for a disabled patient.

However:

- We saw evidence of good discharge planning in patient notes.

Summary of this inspection

- The provider had a multi-faith room that was regularly accessible to patients. Patients were aware of how to make a complaint and were supported by staff when this was needed.
- There was good access to the garden areas and fresh air.

Are services well-led?

Good

We rated well-led as **good** because:

- Staff reported being well supported by their ward managers and local management team.
- The provider had systems in place to demonstrate a commitment towards continual improvement for example the Aspire programme for HCAs to undertake their nurse training.
- The provider involved patients in the discussions about the running of the service.
- The provider offered a programme of continuing professional development (CPD), for staff, for example the living leader leadership training.

However:

- The provider did not identify that 1-1 management supervision records were inconsistent and poorly documented.
- Frontline staff reported feeling isolated from the Northampton head office and told us they did not regularly see senior management in Essex. Senior Managers did regularly visit the Essex site but it was unclear whether they met with ward based staff.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Staff completed mandatory training in the Mental Health Act (MHA) primarily delivered through the corporate induction programme. Overall compliance for staff in clinical areas was 91%. Staff were not required to complete mandatory refresher training, and the provider could not demonstrate that all staff had received training in the revised Mental Health Act Code of Practice. This meant that staff might not be working to the most recent guidelines.
- Staff completed consent to treatment and capacity assessments for patients. The relevant paperwork (T2 and T3 forms) were not always attached to medication charts for staff reference.
- Staff we spoke with told us they explained to patients their rights under the Mental Health Act on admission and routinely thereafter. This was recorded in the patient notes.
- Administrative support and legal advice on implementation of the Mental Health Act Code of Practice was available to staff from a central team.
- Detention paperwork was not always recorded properly, not always in date, and not always stored in the appropriate place in patient notes.
- Patients could access the independent mental health advisor. An independent advocate is specially trained to support people to understand their rights under the Mental Health Act and participate in decisions about their care and treatment.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed mandatory training in the Mental Health Act and Mental Capacity Act, which included Deprivation of Liberty Safeguards information for staff reference. This was delivered through the corporate induction programme. Overall compliance for staff in clinical areas was 91%.
- The provider did not include Mental Capacity Act refresher training in their mandatory training matrix. They could not be sure all staff were aware of their responsibilities under the Act. However, the staff we spoke with had a good understanding of the principals of the Act and how this was applied in practice. Staff completed decision specific assessments for patients who lacked capacity and recorded these appropriately. However, unqualified staff we spoke to said they were not involved in Mental Capacity Act assessments or Deprivation of Liberty Safeguards applications so were not knowledgeable of them.
- Independent mental capacity advocates were available to support patients who lacked capacity. The provider had a policy on the Mental Capacity Act, which included Deprivation of Liberty Safeguards information for staff reference.
- Some staff told us they get advice from medical staff and social workers on the application of the Mental Capacity Act.
- The Mental Capacity Act administration team were responsible for the monitoring of adherence to the Mental Capacity Act within the service.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Forensic inpatient/ secure wards	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	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	Requires improvement
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

- The provider had installed mirrors on wards where staff did not have clear lines of sight.
- The provider had completed a ligature risk assessment. A ligature risk is a fixed item to which a patient might tie something for the purpose of self-strangulation. However, the assessment did not identify all risks or state how these risks should be managed. For example, wards had paper towel and soap dispensers that were screwed to the walls and could be used as ligature points. We raised this concern with senior managers who advised these dispensers would be replaced.
- There was no ligature risk assessment completed for the garden on Audley ward.
- Staff did not have access to a rapid tranquilisation flow chart for easy reference when administering medication to patients in emergency situations. This meant staff might not have been aware of the up to date procedure.
- The seclusion rooms met the guidelines contained in the Mental Health Act Code of Practice. However, the toilet door in the seclusion room on Audley ward had been damaged and not replaced.
- All areas of the wards were clean and in good decorative order. Furnishings were well maintained, comfortable and suitable for the environment.
- The door leading to the intensive care unit area on Frinton ward was made up of clear glass. This meant that other patients could see into the area. This raised issues of privacy and dignity. However, the provider installed privacy frosting to the door while we were there to resolve this.
- Wards had well equipped clinic rooms with appropriate equipment. Staff completed regular checks on all equipment and kept accurate records.
- Staff had personal alarms across all wards. Reception staff issued personal alarms to visitors to ensure safety.
- Staff had fire cards across all wards. Reception staff issued fire cards to visitors, which were handed in at each point of entry to ensure safe evacuation in the event of a fire.
- Cleaning records were up to date and we saw evidence that regular cleaning and audits were taking place.

Safe staffing

- The provider supplied data relating to their staffing establishment. The data showed the total establishment of qualified nurses whole time equivalent (WTE) was 27 and the total establishment for nursing assistants was 41.
- The provider supplied data relating to their staffing vacancies and staff turnover.
- The data showed between March 2016 and June 2016 there were five vacancies for qualified staff, four of which were on Frinton Ward.
- Data provided showed there had been a major campaign to focus on the retention and recruitment of qualified staff. It resulted in a total of 1,002 employees being hired during the 2015 to 2016 period. The recruitment strategy had also been revised to enable better planning.
- Data provided showed the number of shifts filled by bank or agency between March 2016 and June 2016 across both wards was 1,510.

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

Requires improvement

- Between 1 July 2015 and 31 June 2016, data showed staff vacancies were three per cent with three leavers for Frinton ward and no vacancies with four leavers for Audley ward.
- The provider used high numbers of bureau and agency staff to cover shift vacancies. Where possible, the provider used regular bureau and agency staff to promote continuity of care of patients. However, between 12 September 2016 and 30 September 2016, the staff records for Frinton ward showed 56 different bureau and agency staff employed. Of these, 42 staff had completed two or less shifts in this period. The most shifts completed by bureau of agency staff was eight during this period. On Audley ward, 13 different bureau or agency staff had covered day shifts. None of the bureau or agency staff worked more than two shifts in the above timeframe. We were concerned that this affected continuity of care for patients.
- The provider employed a bureau co-ordinator with responsibility for booking staff to ensure wards had adequate staffing for care and treatment for patients. The provider used an electronic system to manage staffing and the booking of bureau and agency staff.
- The provider supplied data, which showed the number of shifts not covered with regular, bank or agency staff. For example, between 5 March and 30 May 2016, Frinton ward had 19 health care assistant (HCA) day shifts and two night shifts unfilled. During the same period, four day shifts and one night shift, requiring a qualified staff member were left unfilled. The provider told us that when shifts could not be filled, staff were re-deployed from other wards. On occasions, senior staff would place themselves on the wards to ensure safe staffing levels were maintained.
- There were discrepancies between the provider's electronic staffing system and duty rotas. We found examples where recorded staffing levels differed between the systems in use. We bought this to the attention of senior staff. The provider could not be certain that their records accurately reflected staff on duty.
- Between the 1 July 2015 and 31 June 2016, the data provided showed a staff sickness rate across the two PICU wards of five per cent.
- Most patients told us they have not had any leave or activities cancelled due to lack of staff. Three patients said they had their gym session cancelled once.
- The provider supplied data for staff training that showed an overall compliance rate of 79%, against an aspirational target set by NHS England of 95%. Data provided showed compliance rates, for example: intermediate life support, 89%, food hygiene level 1, 80%, food hygiene level 2, 42%, food hygiene level 3, 50%. The provider had systems for monitoring compliance with mandatory training. However, compliance rates for Frinton ward were higher than the site average at 89% compliance overall.
- We saw that all staff adhered to infection control principles including handwashing.

Assessing and managing risk to patients and staff

- Data supplied by the provider showed between 1 September 2015 and 31 May 2016 there were 71 incidents of seclusion and 154 incidents of restraint involving 33 different patients. Of the 154 incidents 54 of these were prone (face down) restraint. This represented approximately one-third of all restraints resulting in prone restraint. This is not in line with the Mental Health Act Code of Practice.The Mental Health Act Code of Practice 26.70 states that "no patient should be placed in the prone position unless there are congent reasons for doing so". We considered the use of prone restraint to be high. Of the 54 incidents of prone restraint, 30 resulted in patients being administered rapid tranquilisation. The highest numbers of prone restraint and rapid tranquilisation occurred on Frinton Ward, with 37 prone restraints and 22 incidents of rapid tranquilisation.
- Staff received training in de-escalation techniques and physical interventions. The provider was changing the training on the prevention and management of violence and aggression (PMVA) to management of actual or potential aggression (MAPA). 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 the one day foundation course had been completed by 83% of staff and the five day programme had been completed by 39% of staff.
- The provider had service level agreements in place with five local agencies to ensure that agency staff had undergone training in physical intervention.

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

Requires improvement

- We looked at 12 patient care records. Staff completed comprehensive risk assessments for patients and updated these regularly. The provider used nationally recognised risk assessment tools, for example threshold assessment grid.
- Staff were able to describe the relational security guidelines and a poster was observed on the ward office walls.
- We reviewed 20 medication cards. There were five incidents of as required medication (prn) not being reviewed for more than 14 days; these were not reviewed according to the National Institute for Health and Care Excellence (NICE) guidelines. PRN is an abbreviation used in reference to dosage of prescribed medication that is not scheduled; instead, the decision of when to administer the drug is left to the nurse, caregiver, or patient (such as in patient-controlled analgesia).
- The provider had a seclusion policy for staff reference, which had been updated to include changes to the Code of Practice. Seclusion refers to the supervised confinement of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance, which is likely to cause harm to others (Mental Health Act Code of Practice 26.103).
- Staff were not consistently recognising when patients had been secluded or subject to long-term segregation. Staff referred to patients being placed in the ICU or having 'time out'. However, on further review, this practice was found to constitute seclusion. This meant patients were not being afforded the safeguards contained in the Mental Health Act Code of Practice. We drew this to the attention of senior management who advised they would take immediate action to address this concern. Where staff had recognised that patients had been secluded, we found seclusion records to be in order. At our follow-up visit, we spoke with staff on all wards. Staff spoken to told us, following our inspection, the provider had reminded staff of their responsibilities to recognise and recorded seclusion in accordance with the code of practice.
- Frinton and Audley wards did not have the name of the prescriber printed anywhere on the medication cards, so it was not possible to see who had prescribed or made changes to medication.
- 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. However, on Audley ward we found medication (Glugogen) had been left out of the fridge. This meant the provider could not be sure this medication was safe for patient use. We also found some medication (Methadone) which had expired on 12 August 2016.
- Safeguarding training was mandatory for all staff. The provider supplied data as at August 2016 showing 92% of staff were compliant with safeguarding level 1, 90% with level 2, and 73% with level 3. Staff we spoke with were able to explain the safeguarding process.
- The provider had arrangements for children to visit.

Track record on safety

- Between 10 January 2015 and 30 June 2016 Frinton and Audley wards reported six serious incidents requiring investigation, relating to allegations or incidents of absconsion, physical health concerns, medication errors, inappropriate force used by staff, sexually inappropriate behaviour by patients and incorrect paperwork.

Reporting incidents and learning from when things go wrong

- Incidents were reported via an electronic incident reporting form. Staff we spoke to knew how to report incidents using the electronic reporting system.
- Staff told us that incidents were discussed in handovers and at team meetings. Some staff told us they did have access to debriefs and support following incidents.

Duty of Candour

- Data showed the provider had developed a weekly publication and CPD sessions for staff, which outlined their duty of candour roles and responsibilities.

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

(for example, treatment is effective)

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

Requires improvement

Requires improvement

Assessment of needs and planning of care

- The provider used an electronic database to manage all patient care records. Staff had individual passwords to access the system for information and updates.
- We reviewed 17 patient care records. All patients received a comprehensive and timely assessment on admission.
- Staff completed basic physical health assessment checks for patients on admission and completed care plans to address any needs. Staff provided appropriate on-going physical health checks, as appropriate. There was evidence of informed consent and assessment of mental capacity, as required.
- Staff completed holistic and person centered care plans for patients, and reviewed these at regular patient care plan update meetings.
- Staff offered all patients a copy of their care plan; this was repeated at regular intervals if initially declined.
- Staff completed positive behavioural support plans (PBS) for patients.
- We looked at the care records for three patients in long-term segregation and found that they all had long-term segregation care plans. These had been reviewed and updated regularly.
- The provider supplied data that showed staff did complete clinical audits on the wards.

Best practice in treatment and care

- The provider used the nationally recognised outcome measure Health of the Nation Outcome Scales (HoNOS).
- We saw up to date care plans, physical health examination on admission and evidence of on-going physical healthcare where applicable. There was evidence of informed consent and assessment of mental capacity.
- Patients had access to psychological therapies, recommended by the National Institute for Health and Care Excellence (NICE) for example dialectical behaviour therapy (DBT) and cognitive behavioural therapy (CBT).
- We reviewed 20 medication cards and found 15 of these to be prescribed in accordance with National Institute for Health and Care Excellence (NICE) guidance.
- Staff completed on-going assessments of physical health care needs for patients and records showed involvement of specialists, where needed. A physical healthcare nurse was employed to assist with physical healthcare assessments and monitoring.

Skilled staff to deliver care

- The provider did not have an effective management supervision structure. Records were inconsistent and poorly documented. There was no data made available to show management supervision rates achieved. The provider supplied clinical supervision data that showed the rates as Audley ward 97%, Frinton ward 94%.
- The provider had an induction programme for all new employees, which included their mandatory training needs. Processes were in place to ensure that agency staff employed in the service had received appropriate training that met the needs of the patients.
- Specialist advice from a dietician, physical health lead, and gym instructors was available. The Aspire programme provided the opportunity for HCAs to undergo training to become qualified nurses.
- The provider supplied annual appraisal data that showed the rates as Frinton ward 100%, Audley ward 82.4%.
- There was a multidisciplinary team across the PICU of doctors, nurses, occupational therapists (OT), physical health care nurse, psychologists, social workers, and pharmacists.

Multi-disciplinary and inter-agency team work

- Staff attended morning MDT handover meetings, weekly meetings to discuss patient care and shift handovers.
- Staff worked with both internal and external agencies including local authorities, ministry of justice, police and chaplaincy.

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

- Staff completed mandatory training in the Mental Health Act (MHA) and Mental Capacity Act (MCA), which included Deprivation of Liberty Safeguards (DoLS) information for staff reference. This was delivered through the corporate induction programme. Overall compliance for staff in clinical areas was 91%. Staff were not required to complete mandatory refresher training, there were no data available to show how many staff had completed the on-line refresher, and the provider

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

Requires improvement

could not demonstrate that all staff had received training in the revised Mental Health Act Code of Practice. This meant that staff might not be working to the most recent guidelines.

- All patients receiving care and treatment at the time of inspection were detained under the Mental Health Act 1983 (MHA).
- Staff knew how to contact the Mental Health Act office for advice when needed. The provider completed Mental Health Act detention paperwork correctly and had effective systems in place for updating and storing records. The mental health act office completed audits providing an effective system for checking Mental Health Act documentation.
- Staff met regularly with patients to ensure they were aware of their rights under the Mental Health Act.
- Staff recorded these meetings in the electronic patient record.
- Independent mental health advocates (IMHAs) were available to patients. The provider placed information on how to access IMHA services on the ward noticeboards.

Good practice in applying the Mental Capacity Act

- Staff completed mandatory training in the Mental Health Act (MHA) and Mental Capacity Act (MCA), which included Deprivation of Liberty Safeguards (DoLS) information for staff reference. This was delivered through the corporate induction programme. Overall compliance for staff in clinical areas is 91%. Staff were not required to complete mandatory refresher training.
- The staff we spoke with had a good understanding of the principals of the Act and how this was applied in practice. Staff completed decision specific assessments for patients who lacked capacity and recorded these appropriately. However, unqualified staff we spoke to said they were not involved in Mental Capacity Act assessments or Deprivation of Liberty Safeguards applications so were not knowledgeable of them.

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

Good

Kindness, dignity, respect and support

- We observed respectful and dignified interactions between staff and patients. Patients told us that most staff treated them with dignity and respect.
- We found that staff were passionate and enthusiastic about providing care to patients with complex needs. They explained to us how they delivered care to individual patients. This demonstrated that they had a good understanding of the specific care and treatment needs of their patients.

The involvement of people in the care they receive

- We saw evidence in records of patients' involvement in their care plans. Staff offered all patients copies of their care plans for their reference
- We spoke to nine patients. Eight patients told us they had been involved in their care planning. One patient was unsure.
- Patients attended their care plan update meetings with the multidisciplinary team. We attended one meeting and found good involvement from the team in discussing the patient's progress and ongoing needs. We observed the patient was involved throughout and encouraged to discuss issues of concern, for example, prescribed medication and access to leave.
- Independent mental capacity advocates were available to patients when required. The provider had noticeboards with information for patients on how to access a variety of advocacy services.
- Staff held a weekly community meeting where patients could discuss ward issues with staff. We observed a community meeting and saw evidence of actions recorded in minutes. Patients also attended a monthly patient forum where issues could be further discussed.
- Where appropriate, staff ensured patients' families and carers were involved in their care.

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

- We saw evidence of good discharge planning in patients' care records.
- The average bed occupancy in the six months preceding September 2016 on Frinton ward was 70% and Audley ward 73%. These were both lower than the national average (85%) recommended for adult in-patient mental healthcare. This meant that the provider had beds available for patient care.
- The provider supplied data, which showed the number of out of area placements. However, data was not available specific to the PICU service and included all patients receiving care and treatment at this hospital. The data provided showed the number of out of area patients in the women's pathway in the six months preceding inspection was 39. The number of out of area patients in the men's pathway in the six months preceding inspection was 37.
- The provider had specific care pathways for both male and female patients within their service. Patients would be moved through these pathways, according to individual needs.
- The provider reported no delayed discharges during the period 18 January 2016 to 13 April 2016.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider was in the process of replacing curtain rails and curtains to reduce identified risks to patients. However, some patients' rooms had been left without curtains and not all windows had sufficient frosting to promote privacy and dignity. For example, Frinton ward had rooms with windows facing the garden that were only partly frosted. This meant that some rooms could be seen into from the opposite building. We highlighted this to senior staff. During our follow up inspection, we found some of this work had been completed, with plans to complete the remaining work immediately.
- The door leading to ICU on Frinton ward was clear glass. This meant that other patients could see into the area. This raised issues of privacy and dignity, which we addressed with the provider who resolved this during our visit.
- Most patients told us that the bathroom, toilet and kitchen areas were always clean, and they felt that the furnishings and fittings were well maintained.
- Patients were able to personalise their bedrooms.
- The ward had access to a garden area with facilities for patients who smoked. Smoking and garden times were displayed on the notice board.
- Patients told us they were able to make phone calls in privacy, and there was somewhere they could see visitors.
- Most patients told us they had somewhere lockable to keep their possessions safely.
- Patients were not able to make their own drinks and snacks, but they told us staff do this for them when requested.
- The provider had individual wards activity timetables covering seven days a week. However, ten patients across the site told us they only have activities from Monday to Friday.

Meeting the needs of all people who use the service

- The wards had notice boards containing a range of information relating to activities, treatment, safeguarding, patients' rights and complaint information. This included pictorial information available for patients.
- There were no leaflets in other languages observed during the visit, but staff confirmed that these were available when required. Staff were able to access interpreters to assist communication with patients, as needed.
- Patients could access a multi-faith room on the hospital site and chaplaincy services were available for a range of faiths and beliefs.
- The provider supplied dietary choices, which met dietary requirements of different religious and cultural needs.
- Smoking and garden times, spiritual/religious information, safeguarding and food choices were displayed on the noticeboard.

Listening to and learning from concerns and complaints

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

Requires improvement

- The provider had systems in place for recording and monitoring of complaints. Staff told us that patients were helped to make and write complaints where appropriate and staff assist patients with the complaints process as needed. Information on how to make a complaint was available on the wards.
- Patients confirmed they knew how to complain and felt able to if necessary.
- Data provided showed there were 23 complaints received for Audley and Frinton wards for the year to September 2016. Of these eight were upheld.
- Patients raised some complaints in the community meetings, and staff advised if they should take this on to the patient forum.

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

Good

Vision and values

- Most staff we spoke to knew the provider's vision and values. They were able to explain how these worked in practice.
- Most staff knew who the most senior managers at the Charity's head office based at Northampton were, but many said they were not visible on the wards.

Good governance

- The provider had systems for monitoring compliance with mandatory training.
- The provider had systems for reporting and recording incidents. Staff received red top alert emails, which highlighted incidents from across the organisation, and included actions and lessons learned.
- Staff told us that they got feedback through monthly ward meetings and MDT meetings. One manager told us that feedback is through patient meetings, health & safety meetings, monthly staff meetings, multidisciplinary team meetings (MDT) and management and clinical supervision.
- The provider used quality dashboards to monitor key performance indicators, for example clinical supervision and mandatory training.

Leadership, morale and staff engagement

- Staff on the wards reported that ward managers were approachable and supportive.
- All staff we spoke with said they felt able to raise concerns if necessary, without fear of victimisation.
- All staff we spoke with said they were happy in their role.
- Data provided showed staff sickness in the PICU service as Frinton ward five per cent and Audley ward five per cent.
- Staff were offered the opportunity to give feedback on services by completing the staff survey and questionnaires.

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

- The provider had installed mirrors on wards where staff did not have clear lines of sight.
- The provider had completed a ligature risk assessment; a ligature risk is a fixed item to which a patient might tie something for the purpose of self strangulation. However, the assessment did not identify all risks or state how these risks should be managed. For example, wards had paper towel and soap dispensers that were screwed to the walls and could be used as ligature points. We raised this concern with senior managers who advised these dispensers would be replaced.
- One towel dispenser on Colne ward was unlocked and unsafe in a communal toilet and had not been fixed when initially reported. The inside door handle on the patient telephone booth on Maldon ward was a ligature risk and not mitigated in the ligature audit; staff told us the use of the booth was not always supervised.
- All areas of the ward were clean and in good decorative order. Furnishings were well maintained, comfortable and suitable for the environment.
- Staff had personal alarms across all wards. Reception staff issued personal alarms to visitors to ensure safety. Danbury ward did not have nurse call alarms in the rooms.
- Staff had fire cards across all wards. Reception staff issued fire cards to visitors, which were handed in at each point of entry to wards to ensure safety.
- Wards had well equipped clinic rooms with appropriate equipment. Staff completed regular checks on all equipment and kept accurate records.
- The seclusion rooms met the guidelines contained in the Mental Health Act code of practice.
- We saw that all staff adhered to infection control principles including handwashing.

Safe staffing

- The provider supplied data between March and June 2016, showing the total establishment of qualified nurses whole time equivalent (WTE) at 42 and total establishment nursing assistants WTE at 66. The provider reported eight vacancies for qualified nurses and 19 vacancies for health care assistants. In the 12 month period to June 2016, there were 11 staff leavers.
- Data provided showed there had been a major campaign to focus on the retention and recruitment of qualified staff. It resulted in a total of 1,002 employees being hired during the 2015 to 2016 period. The recruitment strategy had also been revised to enable better planning.
- The provider reported a high number of bureau and agency staff being used to cover staff shortages. Data provided showed, between March and June 2016, 1,461 vacant shifts were filled by bank staff and 826 shifts were filled by agency staff.
- The provider advised that, where possible, regular bank or agency staff were used to promote continuity of care for patients. However, we reviewed records between 12 and 30 September 2016 and found on Danbury ward, 29 different bureau or agency staff had been used to cover day shifts. Of these, 20 had worked two or less shifts in that period. To cover night shifts, 26 different bureau or agency staff were used. Twenty-three of these staff had worked two or less shifts. On Maldon ward, eight

different bureau or agency staff had been used to cover day shifts. Of these, five had worked two or less shifts in that period. On Colne ward, 31 different bureau or agency staff had been used. Of these staff, 28 had worked two or less shifts. This meant that there was a risk of poor continuity of care for patients on the wards.

- The provider supplied data, which showed shifts were often left unfilled. For example, Maldon ward was often short of staff at night. The electronic staffing system showed a period of six weeks with a shortage of staff. On 28 and 29 August 2016 there were no qualified staff on duty, and 10 out of 22 days were short staffed. The provider told us when shift vacancies could not be filled staff were re-deployed to ensure safe staffing levels for patient care. Senior managers would assist on the wards when needed.
- The provider used an electronic system to manage staffing and the booking of bureau and agency staff. The provider employed a bureau co-ordinator with responsibility for booking staff to ensure wards had adequate staffing for care and treatment for patients. Most patients told us they had not had any leave or activities cancelled due to lack of staff. Three patients said they had their gym session cancelled once.
- There were discrepancies between the provider's electronic staffing system and duty rotas. We found examples where recorded staffing levels differed between the systems in use. The provider could not be certain that their records accurately reflected staff on duty. We reviewed staffing records and found discrepancies between the electronic staffing system and rotas. For example, at the beginning of the electronic system it stated there were two qualified nurses and three unqualified staff on shift. However, the total stated there were four staff on shift. We brought this to the attention of senior staff.
- Between 1 July 2015 and 31 June 2016, the data provided showed a staff sickness rate for Colne ward seven per cent, Maldon ward six per cent, Hadleigh ward four per cent and Danbury ward nine per cent.
- Data provided showed staff sickness in the forensic service was: Colne ward seven per cent; Maldon ward six per cent; Hadleigh ward four per cent and Danbury ward nine per cent.
- The provider supplied data for staff training that showed an overall compliance rate of 79%, against an aspirational target set by NHS England of 95%. Data provided showed compliance rates, for example: intermediate life support, 89%, food hygiene level 1, 80%, food hygiene level 2, 42%, food hygiene level 3, 50%. The provider had systems for monitoring compliance with mandatory training.
- However, compliance rates for Maldon ward were higher than the site average at 92% compliance overall.

Assessing and managing risk to patients and staff

- The provider supplied data, which showed between 1 September 2015 and 31 May 2016 there were 80 incidents of seclusion and 153 incidents of restraint on 25 different patients. Of the 153 incidents, 55 of these were prone restraint (face down). Of these 27 resulted in rapid tranquilisation. This is not in line with the Mental Health Act Code of Practice The Mental Health Act Code of Practice 26.70 states that "no patient should be placed in the prone position unless there are cogent reasons for doing so". We considered the use of prone restraint to be high.
- The provider had a seclusion policy for staff reference, which had been updated to include changes to the code of practice.
- Staff were not consistently recognising when patients had been secluded or subject to long-term segregation. Staff referred to patients being placed in the ICU or having 'time out'. However, on further review, this practice was found to constitute seclusion. This meant patients were not being afforded the safeguards contained in the Mental Health Act Code of Practice. We drew this to the attention of senior management who advised they would take immediate action to address this concern. Where staff had recognised that patients had been secluded, we found seclusion records to be in order. At our follow-up visit, we spoke with staff on all wards. Staff spoken to told us, following our inspection, the provider had reminded staff of their responsibilities to recognise and record seclusion in accordance with the code of practice.
- Staff received training in de-escalation techniques and physical interventions. The provider was changing the training on the prevention and management of violence and aggression (PMVA) to management of actual or potential aggression (MAPA). 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 the one day foundation course had been completed by 83% of

staff and the five day programme had been completed by 39% of staff. Staff told us that the MAPA trained staff always respond initially with PMVA trained staff supporting. Most staff felt that the changeover was working well.

- The provider had service level agreements in place with five local agencies to ensure that agency staff had undergone training in physical intervention.
- Safeguarding training was mandatory for all staff. The provider supplied data showing 95% of staff were compliant with safeguarding level 1, 93% with level 2, and 46% with level 3. Staff we spoke with were able to explain the safeguarding process.
- The provider had arrangements for children to visit.
- We found blanket restrictions on some wards, for example on Colne ward the bedroom corridor was locked restricting access to bedrooms during therapy times.
- The Provider held copies of the medicines management policy in the clinic rooms for staff reference; on Hadleigh ward, this policy was out of date. This meant staff might not have quick access to up to date information when administering medication to patients. However, the up to date policy was available to staff on the intranet.
- Staff were able to describe the relational security guidelines and this poster was observed on the ward office walls.
- We reviewed 54 medication cards. There were 11 incidents of as required (prn) medication not being reviewed for more than 14 days across all wards. PRN is an abbreviation used in reference to dosage of prescribed medication that is not scheduled; instead, the decision of when to administer the drug is left to the nurse, caregiver, or patient (such as in patient-controlled analgesia). This meant 11 medication cards were not reviewed according to the National Institute for Health and Care Excellence (NICE) guidelines. One patient on Maldon ward was given medication (promethazine 50mg) on the verbal order from a doctor. The doctor however failed to complete the Mental Health Act, section 62 paperwork. This meant there was no legal authority to administer this medication.
- We found that medication cards were not always filled in correctly. Danbury, Hadleigh and Colne wards did not have the name of the prescriber printed anywhere on the patients' medication chart. On Hadleigh ward, several PRN (as needed) psychotropics had not been reviewed since 1 July 2016. Danbury ward did not have notification of where an epi-pen could be found in an emergency. One patient did not have his PRN medication recorded on the electronic recording system.
- There was only one emergency bag shared between Danbury and Hadleigh wards, Colne ward shared Frinton ward's. This meant there might be a delay in staff accessing equipment in the event of an emergency. The response times were tested on a calendar rota. Data provided showed the last one dated 17 May 2016. There was no evidence to show that safe policy was not being adhered to.
- Hadleigh ward had expired medications for example one liquid haloperidol expired on the 12 September 2016 and one Salbutamol inhaler expired on August 2015. There were incomplete sample staff signatures. Sample signatures were required to ensure that nurses administering medication to patients could be identified, if required. On Colne, ward pharmacy contact details could not be seen or found by staff. Two products of limited shelf life were without 'opened' or 'use by' dates. Both controlled drugs cabinet keys were on the same key ring. The policy for rapid tranquilisation was not on display or easily accessible. Staff did not have access to a rapid tranquilisation flow chart for easy reference when administering medication to patients in emergency situations. This meant staff might not have been aware of the up to date procedure. The medications management policy was out of date.
- The fridge and room temperature in the clinic room on Maldon ward were above recommended temperatures due to a failure with the air conditioning. We were told that this is due to be fixed but no date given.

Track record on safety

- From 27 November 2015 and 10 April 2016 Colne ward had nine serious incidents requiring investigation reported relating to allegations or incidents of absconsion, self-harm, signature missing on medication paperwork and drugs cabinet left unlocked, and injury caused to patient during restraint. Danbury ward had five serious incidents requiring investigation relating to incidents of absconsion, self-harm, alleged missing personal belongings. Hadleigh ward had seven serious incidents requiring investigation relating to absconsion, self-harm, suspicion of cannabis found in patient's

room, creation of a weapon and medication paperwork and drugs cabinet left unlocked. Maldon had three serious incidents requiring investigation reported relating to self-harm.

Reporting incidents and learning from when things go wrong

- Incidents were reported via an electronic incident reporting form. Most staff knew how to report incidents and used the electronic reporting system.
- Staff told us that incidents were discussed in handover and at team meetings. Most staff told us they do have access to debriefs and support following incidents.
- The provider had developed a weekly publication and CPD sessions for staff which outlined their duty of candour roles and responsibilities.

Duty of Candour

- Data showed the provider had developed a weekly publication and CPD sessions for staff which outlined their duty of candour roles and responsibilities.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- The provider used nationally recognised assessment tools, for example threshold assessment grid. We looked at two patient records on Danbury ward. Both patients had up to date risk assessments. These were reviewed regularly. We saw evidence of up to date care plans, physical health examination on admission and evidence of on-going physical healthcare where applicable. There was evidence of informed consent and assessment of mental capacity.
- We reviewed eight patient care records. All received a comprehensive and timely assessment on admission. Nursing staff had completed basic physical health assessment checks and observations on admission and regularly thereafter where appropriate.
- Staff completed positive behavioural support plans for patients. We found these contained a range of needs and actions for patient care with evidence of holistic and recovery-orientated recording.
- The provider supplied data that showed staff did complete clinical audits on the wards.

Best practice in treatment and care

- We saw eight patient records that showed up to date care plans, physical health examination on admission and evidence of on-going physical healthcare where applicable. There was evidence of informed consent and assessment of mental capacity.
- The provider used the nationally recognised outcome measure Health of the Nation Outcome Scales (HoNOS).
- We reviewed 54 medication cards and found 45 of these to be prescribed in accordance with National Institute for Health and Care Excellence (NICE) guidance. There were nine occasions of as required medication (PRN) not reviewed for more than 14 days. This meant they were not reviewed according to NICE guidelines. Care records showed that there was evidence of on-going physical care where applicable. One patient told us her care plan stated she should be sent to A & E when she complained of stomach pains, but this had not been followed on one occasion being left for 18 hours. Staff confirmed the care plan had not been followed.

Skilled staff to deliver care

- The provider did not have an effective management supervision structure. Records were inconsistent and poorly documented. There was no data made available to show management supervision rates achieved. The provider supplied clinical supervision data that showed the rates as: Colne ward 93%, Danbury ward 97%, Hadleigh ward 96%, and Maldon ward 91%.
- The provider supplied annual appraisal data that showed the rates as: Maldon ward 100%, Danbury ward 82%, and Colne ward 94%. However, only 64% of staff on Hadleigh ward had received an appraisal in line with the provider's policy.
- New staff had an induction programme prior to working on the wards. Managers said that checks were made to ensure that agency staff used had received the required training prior to being booked to work shifts.

Requires improvement

Forensic inpatient/secure wards

- There was a multidisciplinary team across the forensic service to provide care for patients. This included doctors, nurses, occupational therapists (OT), physical health care nurse, psychologists, social workers, and pharmacists.

Multi-disciplinary and inter-agency team work

- There were regular morning MDT handover meetings and weekly meetings to discuss patient care and treatment, in addition to daily shift handovers.
- Staff worked with both internal and external agencies including local authorities, ministry of justice, police and chaplaincy.

Adherence to the MHA and the MHA Code of Practice

- Staff completed mandatory training in the Mental Health Act (MHA) and Mental Capacity Act (MCA), which included Deprivation of Liberty Safeguards (DoLS) information for staff reference. This was delivered through the corporate induction programme. Overall compliance for staff in clinical areas was 91%. Staff were not required to complete mandatory refresher training, and the provider could not demonstrate that all staff had received training in the revised Mental Health Act Code of Practice. This meant that staff might not be working to the most recent guidelines.
- Staff knew how to contact the Mental Health Act office for advice when needed.
- The Mental Health Act office completed audits providing an effective system for checking Mental Health Act documentation.
- Staff explained patients their rights under section 132 of the Mental Health Act and recorded this in patient records.
- The provider placed information for patients on how to access independent mental health advocacy services (IMHA) on the ward noticeboards.

Good practice in applying the MCA

- Staff completed mandatory training in the Mental Health Act (MHA) and Mental Capacity Act (MCA), which included Deprivation of Liberty Safeguards (DoLS) information for staff reference. This was delivered through the corporate induction programme. Overall compliance for staff in clinical areas was 91%. Staff were not required to complete mandatory refresher training. No patients were subject to a Deprivation of Liberty Safeguard.
- Staff's knowledge of the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards varied. For example, unqualified staff we spoke to said they were not involved in Mental Capacity Act assessments or Deprivation of Liberty Safeguards applications so were not knowledgeable of them. Other staff told us that the doctors generally dealt with Mental Capacity Act, consent to treatment and Deprivation of Liberty Safeguards.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity respect and support

- We observed respectful and dignified interactions between staff and patients. Patients told us that most staff treated them with dignity and respect.
- We found that staff were passionate and enthusiastic about providing care to patients with complex needs. They explained to us how they delivered care to individual patients. This demonstrated that they had a good understanding of the specific care and treatment needs of their patients.

The involvement of people in the care they receive

- We saw evidence in patient records of their involvement in their care plans. These showed that all patients were offered copies of their care plans, this was repeated at regular intervals if initially declined.
- We spoke to 15 patients of which 10 said they had been involved in their care planning.
- There was information on the noticeboards and patients knew how to access advocacy services.
- We observed a weekly community meeting and was told by patients and staff that there was a monthly patient forum for issues to be discussed and actioned where possible.
- Where appropriate, staff ensured patients' families and carers were involved in their care.

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

(for example, to feedback?)

Requires improvement

Forensic inpatient/secure wards

Requires improvement

Access and discharge

- We saw evidence of good discharge planning in patient notes.
- The provider supplied data related to the average bed occupancy from 1 December 2015 until 31 May 2016 was Danbury ward 97%, Hadleigh ward 99%, Colne ward 95% and Maldon ward 81%. This meant that three wards were working at near full capacity over this period and only Maldon ward was working lower than the national average. The recommended level is 85%.
- Data provided showed four delayed discharges during the period 18 January 2016 and 13 April 2016. These were due to difficulties finding appropriate placements for the patients. However, prior to the inspection three of the four had been successfully discharged from St Andrew's Essex.
- The provider supplied data, which showed the number of out of area patients in the women's pathway in the six months preceding inspection was 39. Out of area placements for the men's pathway during this period was 37.
- The provider had specific care pathways for both male and female patients within their service. Patients would be moved through these pathways, according to individual needs.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider was undertaking replacement of curtain fittings. On Hadleigh ward, only three rooms had been fitted with curtains. The provider told us this work was in progress. On Maldon ward, all rooms had curtains, except one room.
- 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.
- Most patients told us that the bathroom, toilet and kitchen areas were always clean, and they felt that the furnishings and fittings were well maintained.
- There was access to the garden where there was a smoking area included.
- The provider had facilities to allow patients to make and receive telephone calls in private. No patients had access to mobile phones.
- One patient told us that hot drinks and snacks were only available between 6am and midnight. However the provider confirmed that hot drinks and snacks were available 24 hours a day at the request of the patient.
- Patients had facilities for the safe storage of their personal possessions.
- The provider had activity timetables for patients, which included weekends. However, three patients told us they needed more activities as these were only Monday to Friday and there was not much to do at weekends and a further three said they would like the internet available at weekends. They felt if they were able to use the internet this would prevent them becoming bored. Minutes from the patients' forum showed this having been discussed, and followed up. However the date for response had passed.

Meeting the needs of all people who use the service

- The evac-chair on Danbury ward had been removed and staff were unsure where it was. This was a risk to patients, with mobility difficulties, in the event of a fire. We reported this to senior managers as an urgent concern and the evac-chair was located and replaced on the ward. The evacuation care plan for one patient on Danbury ward was incomplete.
- The provider had a range of information displayed on the ward and the hospital site relating to activities, treatment, safeguarding, patients' rights and complaint information. This included pictorial information available for patients.
- There were no leaflets in other languages observed during the visit, but staff confirmed that these were available when required. Staff were able to access interpreters to assist communication with patients, as needed.
- There was a multi-faith room, which could be accessed on the hospital site and chaplaincy services were available for a range of faiths and beliefs.
- The provider supplied dietary choices, which met dietary requirements of different religious and cultural needs.
- Staff attended to the physical health care needs of patients appropriately. However, one patient told us

that they were not sent to A & E when complaining of stomach pains, despite a medical condition being recorded in their care plan. Staff confirmed this during the inspection.
- Specialist advice from a dietician, physical health lead, and gym instructors was available.
- There was limited therapeutic space or quiet areas on some wards for family visits, individual interventions, or 1-1 engagement with staff.

Listening to and learning from concerns and complaints

- The provider had systems in place for recording and monitoring of complaints. Staff told us that patients were helped to make and write complaints where appropriate and staff assist patients with the complaints process as needed. Information on how to make a complaint was available on the wards. Data provided showed there were 23 complaints received for Colne, Maldon, Danbury and Hadleigh wards for the year to September 2016. Of these nine were upheld.
- Patients raised some complaints in the community meetings, and were advised if they should take this on to the patient forum to be taken forward.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- Most staff we spoke to knew the provider's vision and values. They were able to explain how these worked in practice.
- Most staff knew who the most senior managers at the Charity's head office based in Northampton were, but many said they were not visible on the wards.

Good governance

- The provider had systems for monitoring compliance with mandatory training.
- Systems were in place for reporting and recording incidents. Most staff were aware of the red top alert folder. This contained red top e-mails alerting all staff of highlighted incidents from across the organisation, and included actions and lessons learned.
- The provider used quality dashboards to monitor key performance indicators, for example clinical supervision and mandatory training.
- The provider did not identify that 1-1 management supervision and records were inconsistent and poorly documented. Therefore, objectives set during the appraisal process, might not be reviewed in accordance with the provider's policy.
- Staff told us that they get feedback through monthly ward meetings, MDT meetings supervision and handovers.

Leadership, morale and staff engagement

- Staff on the ward reported feeling supported and able to approach the ward manager.
- All staff we spoke with said they feel able to complain if necessary without fear of victimisation.
- All staff we spoke with said they were happy in their role, one added it had improved since the pathways changes.
- Staff were offered the opportunity to give feedback on services by completing the staff survey and questionnaires.

Outstanding practice and areas for improvement

Outstanding practice

The Safewards programme was proving successful on Hadleigh ward and was being rolled out on to other wards. This initiative looks at positive behaviours of patients and strives to change staff attitudes.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that ligature risks are identified in the ligature risk assessment with clear plans for how these risks are to be managed.
- The provider must ensure that the privacy and dignity of patients is protected.
- The provider must ensure there are adequate rooms for care and treatment of patients on all wards.
- The provider must ensure that duty rotas accurately reflect the numbers and skills of staff on duty.
- 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 ensure that medication is securely locked away, used within the shelf life/replaced and as required medication (prn) is reviewed within 14 day period.
- The provider must ensure that all practices amounting to seclusion or segregation are recognised, recorded and safeguarded in line with requirements set out in the Mental Health Act Code of Practice.
- The provider must ensure that staff receive management supervision, in accordance with their policy.

Action the provider SHOULD take to improve

- The provider should review their Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training to ensure staff have adequate knowledge for their role.

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 • The provider had not ensured that all patients' rooms had curtains to ensure their privacy and dignity. This was a breach of Regulation 10(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 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not always ensured that medication was kept securely locked away, used within the shelf life/replaced or as required medication (prn) reviewed within 14 day period. This was a breach of Regulation 12(1)(a)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The provider had not ensured that all practices amounting to seclusion or segregation were recognised, recorded and safeguarded in line with requirements set out in the Mental Health Act Code of Practice. This was a breach of Regulation 13(4)(b)

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 • The provider had not ensured there were appropriate rooms within the wards for care and treatment of patients. This was a breach of Regulation 15(1)(c)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had not always ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed that met the needs of the service. • The provider had not ensured that all staff were in receipt of management supervision. This was a breach of Regulation 18(1)(2)(a)