

Cygnnet Hospital Harrow

Quality Report

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

Ratings

Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Harrow as **requires improvement** because:

- The provider did not take sufficient precautions to ensure patients' safety. For patients on Byron ward receiving alcohol detoxification, the service did not measure the level of dependency or symptoms of withdrawal.
- The provider did not always provide care that was sufficiently person centred and appropriate. On Byron ward, staff carried out one to one observations of informal patients without ensuring the patient's consent and understanding.
- On the Springs unit, staff did not always support patients appropriately to keep their bedrooms safe, clean and tidy.
- On Byron ward, there were no designated areas for male and female bedrooms. During enhanced observations, staff propped bedroom doors open. This meant that patients' privacy was compromised.
- On the Springs unit, staff did not meet together to discuss incidents. The staff team did not have the opportunity to learn from incidents and make improvements to the service.

- On Byron ward and the Springs unit, there were no records of concerns raised by staff and patients. This meant that staff and patients felt their views were being ignored and opportunities to improve the service could be missed.

However:

- At our last inspection in October 2015, we said the provider must ensure that staff on the Spring wing and Spring unit complete specialist training in autism. At this inspection, we found this had been addressed.
- Following the last inspection in October 2015, we made a number of recommendations for the service. At this inspection, we found that most of these improvements had been made.
- Overall, patients were positive about the service. Patients described staff as being kind, polite, caring and respectful. Patients felt safe on the wards. Patients also spoke positively about therapeutic activities.

Summary of findings

Our judgements about each of the main services

Service

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

Rating Summary of each main service

We gave an overall rating of **requires improvement** because:

- There were no designated areas for male and female bedrooms. When new patients arrived at the ward, staff allocated them to any bedroom that was available. Staff providing enhanced observations propped bedroom doors open which reduced patient's privacy.
- Completion rates for some mandatory training courses were low.
- There was not adequate care for patients with alcohol detoxification. The ward occasionally admitted patients for alcohol detoxification. While the supervising consultant and therapists were experienced in this work, nursing staff did not have specialist training and the service did not use rating scales to assess the severity of dependence and withdrawal.
- When the service placed informal patients on one-to-one observations, they did not always ensure that patients gave their consent.
- Appropriate systems to listen to and act upon issues and concerns raised by staff and patients were not in place.

Requires improvement



However,

- While building work was causing some disruption, the ward was clean and tidy. The refurbished areas were well equipped with modern, well-designed furniture.

Summary of findings

- There were sufficient staff on the ward to meet patients' needs. Additional staff were allocated to the ward for patients requiring one-to-one observation.
- The service completed a comprehensive range of assessments when patients were admitted.
- The service managed medicines safely.
- Patients had good access to physical healthcare.
- The Mental Health Act was well managed.
- Staff demonstrated a positive, caring attitude towards patients and patients spoke highly of the care they had received from permanent staff. Patients also spoke very highly of the therapeutic activities provided during the week.

Forensic inpatient/ secure wards

Requires improvement



We gave an overall rating of **requires improvement** because:

- Some patient bedrooms were unclean and untidy. Staff were not supporting patients to maintain appropriate standards of hygiene in their bedrooms.
- The ward did not provide learning and feedback from incidents to staff. Staff we spoke with were unable to give examples of learning and we did not see evidence that the team received feedback on incidents.
- Robust systems to respond to and monitor informal complaints were not in place.

However:

- Staff conducted thorough risk assessments of patients. Staff updated risk assessments and carried out physical health checks on a regular basis.

Summary of findings

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

Good



- Care plans were personalised and holistic. Care plans had a multi-disciplinary input. Patients had comprehensive positive behaviour support plans with protocols to support communication.
- Patients had good access to psychological support and opportunities to develop their education and life skills.
- Staff interacted with patients in a caring and compassionate way. Patients spoke positively about staff and said they were kind, respectful and supportive.

We gave an overall rating of **good** because:

- Patients gave positive feedback about the ward and were knowledgeable about their care.
- Staff had access to emergency equipment that they checked regularly and used observations and environmental risk assessments to ensure the ward environment was safe. There was an alarm system for patients and staff to use to get help in an emergency.
- The ward was appropriately staffed and staff were positive about their roles. Staff reflected the organisation's values of being helpful, responsible, respectful, honest and empathetic.
- Individual patient risks were appropriately assessed and managed. Care plans were personalised and recovery focussed. Records showed patients contributed to their care plans and attended weekly meetings with staff to talk about their care.
- There was a full time occupational therapist that supported patients to develop independent living skills and explore their interests.
- Medicines were administered safely.

Summary of findings

However,

- Staff had not disposed of expired medical equipment, such as bandages, saline solution and plasters.
 - Robust systems to record patient leave were not in place and some information to ensure the safety of patients taking leave from the ward was not recorded.
 - Staff recorded all information about care on paper records and we saw errors in some of the care records we looked at.
 - Supervision records we reviewed lacked details and did not have detail about the care and treatment of specific patients.
-

Summary of findings

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Requires improvement 

Cygnnet Hospital Harrow

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; forensic inpatient/secure wards; Long stay / rehabilitation wards for working age adults.

Summary of this inspection

Background to Cygnet Hospital Harrow

The Cygnet Hospital Harrow was registered with the CQC on 15 November 2010. The hospital provides services for up to 44 patients over three wards

Byron Ward is a mixed acute admission ward for up to 18 patients. It provides assessment, diagnosis and treatment for a people with mental health needs and addictions.

Springs Unit is a low-secure ward for up to 16 male patients with autistic spectrum disorders

Springs Wing is a rehabilitation ward for up to 10 male patients with autistic spectrum disorders.

We have inspected Cygnet Hospital Harrow five times since 2010, and published the most recent report in

February 2016. At the last inspection, the service achieved an overall rating of good. The service was rated as requires improvement for effective. We issued a requirement notice about staff being inadequately trained to understand and manage the specific needs of patients with autistic spectrum disorders. During this inspection, we found that these concerns had been addressed.

Cygnet Hospital Harrow is registered to provide the treatment of disease, disorder or injury, and assessment or medical treatment of persons detained under the Mental Health Act 1983

There was a registered manager.

Our inspection team

The team that inspected the service comprised of six CQC inspectors, a pharmacy specialist and two specialist advisors with professional backgrounds in nursing.

Why we carried out this inspection

We undertook this short notice, announced, comprehensive inspection to find out whether the quality of services at Cygnet Hospital Harrow had changed since our last comprehensive inspection in October 2015. At that inspection, we rated the hospital as good overall.

At the last inspection in October 2015, we rated the acute ward, forensic patient/secure ward and the long stay/rehabilitation mental health wards for working age adults as good.

Following the October 2015 inspection, we told the provider it must take the following actions to improve its services:

- The provider must ensure that all staff on Springs wing and Springs unit complete specialist autism training to better understand the needs of patients.

We issued the provider with requirement notice at the previous inspection. This related to the following regulations under the Health and Social Care Act (Regulated Activities) 2014.

- Regulation 18 Staffing

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?

Summary of this inspection

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

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

During the inspection visit, the inspection team:

- visited all three wards, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 20 patients who were using the service
- spoke with the ward manager on each of the three wards.
- observed two ward rounds
- observed a daily meeting for senior staff and administrators
- spoke with 15 other staff members; including doctors, nurses, healthcare assistants, occupational therapists and psychologists.
- spoke with the independent advocate
- spoke with seven other members of staff, including the hospital manager, medical director and clinical services manager
- looked at 16 care and treatment records of patients.
- carried out a specific check of medicines management, including all medicines charts; 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

Patients we spoke with on Byron ward said the staff were kind, polite, helpful and supportive. Patients said that while they may occasionally have a concern about agency staff, their experience of the staff was very positive and supportive. Some patients highlighted the activities provided by the occupational therapy department as a positive part of their care and treatment, and described the occupational therapists as empathic and understanding.

Patients on the Springs unit said staff were caring, respectful and polite. Patients were comfortable raising concerns with staff, although one patient felt staff had not

investigated or handled a complaint appropriately. Patients were happy with the amount of activities offered throughout the week and at weekends and enjoyed access to the garden. Patients highlighted the food as very good with many varied options.

Patients we spoke with on the Springs wing said that staff were approachable and polite and cared about the patients. They said they could speak to staff when they wanted and had regular one-to-one sessions. Patients said they could access fresh air regularly and that their belongings were safe on the ward. Two patients said they could get bored in the evenings and on weekends.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as requires improvement because:

- On Byron ward, the service placed informal patients on one-to-one observations. When doing so, they did not ensure that patients understood why they were being placed on one to one observation.
- On the Springs unit, some patient's bedrooms were not clean or tidy. Staff did not support patients to ensure they maintained an appropriate standard of hygiene
- On the Springs unit, there was no evidence of staff discussing or learning from incidents.
- On Byron ward, there were no designated areas for male and female bedrooms.
- Compliance with five mandatory training courses was below 60%.
- On the Springs wing, staff did not always fully complete all the information required on records of patient leave.
- On the Springs wing, staff did not follow the correct procedure for disposing of medicines.

However,

- The service had installed convex mirrors on the Springs wing to improve visibility.
- All wards were compliant with the hospital's standards for hand hygiene.
- All incidents were reported.
- While the building work at the time of the inspection was disruptive, the refurbished areas of the hospital were well-designed with good quality furniture.
- The service completed and updated comprehensive risk assessments.

Requires improvement



Are services effective?

We rated effective as **good** because:

- In October 2015, we found that staff on the Springs wing and Springs unit had not received specialist autism training to understand the needs of patients. At this inspection, we found that permanent staff had received specialist autism training.
- We found that capacity assessments were being carried out consistently.

Good



Summary of this inspection

- Information about rights was consistently given to informal patients, although we remained concerned about patients' rights regarding observations, as stated above.
- Patients' physical health was regularly monitored and patients' needs were being met.
- Staff completed a comprehensive range of assessments when patients were admitted.
- The psychologist on the Springs unit worked collaboratively with patients to develop positive behaviour support plans that helped staff and patients address difficult behaviours.
- Administration relating to the MHA was well organised.
- On the wards for patients with autistic spectrum disorders, care plans were personalised and holistic.

However,

- On Byron ward, the provider did not ensure that staff had specialist training in alcohol detoxification. Detoxification carries health risks that can be serious and, occasionally, result in death. Without training, staff may have been unable to identify and respond to complications.
- On Byron ward, the provider did not use assessment tools to measure the severity of alcohol dependence and the symptoms of withdrawal. Therefore, the provider could not be sure they were meeting patients' specific need.
- Less than 70% of staff had had an appraisal in the 12 months before the inspection.
- Care plans for patients under section 3 and 37 of the Mental Health Act 1983 (MHA) did not include information about patients' rights to aftercare services.

Are services caring?

We rated caring as good because:

- Staff demonstrated a positive, caring attitude towards patients. Staff interacted with patients in a caring and compassionate way.
- Patients gave positive feedback. Patients spoke highly of the support they received from staff. Patients said staff were kind, respectful and caring.
- Many patients were knowledgeable about their care and were positive about the therapeutic activities that the service provided.
- Patients were actively encouraged to participate in multidisciplinary meetings about their care and treatment.
- The hospital had worked collaboratively with patients in the planning and development of the recovery college.

Good



Summary of this inspection

Are services responsive?

We rated responsive as good because:

- In October 2015, patient information in the Springs unit nursing office was visible from the corridor and the environment on the Springs unit did not meet the specific needs of people with autism. At this inspection, we found that all these matters had been addressed.
- In October 2015, the average length of stay on the Springs wing was 24 months. Some patients had been on the ward for more than five years. At this inspection, the average length of stay had significantly reduced to 16 months.
- On Byron ward, staff provided a decision on whether they could accept a referral within one hour. On the Springs unit, pre-admission assessments were carried out within five days.
- Ward environments were clean and well-maintained throughout the hospital.
- Staff and patients had their meals in a well presented dining room. Chefs cooked fresh, good quality food on site. Chefs could make specific meals to meet the specific dietary needs of patients when necessary.
- All three wards provided a comprehensive programme of therapeutic, rehabilitative and recreational activities that patients enjoyed.
- The Springs wing had employed an artist to work with patients to improve the ward environment.

Good



Are services well-led?

We rated well-led as requires improvement because:

- On Byron ward, the service did not have any systems in place to record concerns raised by patients and staff. This meant that areas for improvement could be overlooked and staff and patients felt ignored when they raised concerns.
- Supervision was taking place across all three wards. However, we found that managers did not keep clear and consistent records of these supervision sessions. Records that were available showed that clinical issues were do not being discussed.
- There were concerns about compliance with mandatory training, supervision records and appraisals. This meant it was difficult for managers to clearly be assured of the competency of their staff.
- The hospital has reduced the number of team leaders on Byron ward. This resulted in the ward manager having significantly high ward load.

Requires improvement



However,

Summary of this inspection

- The hospital manager, clinical services manager and medical director provided leadership across the hospital. As a relatively small hospital, all the staff knew each other well. Daily briefing meetings ensured that senior staff had a good awareness of clinical and administrative issues on the wards.
- The senior management team was leading a programme of development at the hospital to improve facilities and create an additional ward.
- The ward managers on all three wards provided leadership. Staff across all the wards spoke positively about the support received.
- Many members of staff were very positive about working at the hospital and said there was a good sense of morale and teamwork.

Detailed findings from this inspection

Mental Health Act responsibilities

Most patients on the Springs wing and unit, and one-third of patients on Byron Ward, were detained under the Mental Health Act 1983.

Across the hospital, 98% of staff had completed mandatory training on the Mental Health Act (MHA) and the MHA Code of Practice.

The service attached consent and authorisation certificates to patients' medicines charts when required.

Staff spoke to detained patients about the provisions of the MHA they were detained under and about the effect of these provisions. However, staff did not always fully complete records of patients' leave.

Statutory documents relating to the MHA were stored securely in the MHA office. The MHA administrator conducted a MHA audit of each ward every month. This audit covered statutory documents, assessments of capacity to consent to treatment and records of discussions about patients' rights.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the last inspection in October 2015, we found that assessments of capacity to consent to treatment were not carried out on a regular, systematic basis. During this inspection, we saw these took place and staff discussed and considered this in each ward round. Patient files each had a weekly updated sheet to indicate the most recent MDT discussion about the patient's capacity to consent to

treatment and other specific decisions. Where a patient disagreed with the clinician and had capacity to make this decision, this conversation was recorded clearly in their notes. However, only 50% of staff had completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).






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	Requires improvement	Good	Good	Requires improvement	Requires improvement
Forensic inpatient/secure wards	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Long stay/rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	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	Good 
Well-led	Requires improvement 

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

Requires improvement 

Safe and clean environment

- The ward was set out over two floors. During the inspection, building work meant the service had made some temporary changes to the ward. For example, the size of the garden was reduced and the clinic room and nurses' office were temporarily sited in rooms that were formerly patient bedrooms. The ward layout allowed staff to observe patients along corridors. During the inspection, building work was taking place on the ward. This meant that patients were using temporary bedrooms on the first floor. The shift co-ordinator ensured that at least one member of staff was upstairs throughout the shift. Patients had unrestricted access to a laundry room. Staff could not easily observe these areas. The service mitigated risk by using of enhanced observations of patients assessed as presenting a heightened level of risk. CCTV was in operation in communal areas. Staff did not monitor the CCTV. Managers used the footage to investigate complaints and incidents.
- The hospital had installed some anti-ligature features such as collapsible curtain rails, door handles, radiator covers and taps. The ward had completed a comprehensive ligature audit in June 2017. The audit

showed that many doors continued to present a high risk. The ward had an action plan to mitigate these risk including regular reviews of observation levels and multidisciplinary reviews of risk assessments.

- The ward was not fully compliant with guidance on same sex accommodation. On admission, staff allocated patients to any available bedroom. There were no specific areas of ward designated for male bedrooms and female bedrooms. This meant that patients' privacy could be compromised. For example, staff carrying out one-to-one observations often sat in a chair that propped open the bedroom door. This meant that people walking past could see into patient's bedrooms. There was a lounge designated for female patients. All bedrooms had ensuite facilities.
- Staff stored a bag containing equipment for use in an emergency in the nurses' office. Equipment included oxygen, ligature cutters, a defibrillator and adrenaline. All equipment was in date. Nurses completed a record to show they had checked the contents of the emergency bag each week. However, records showed there were gaps of ten days between checks on one occasion in May 2017 and once in June 2017.
- While the building work was causing some disruption, the ward was clean and well-maintained. Refurbished areas were equipped with modern, well-designed furniture.
- The infection control team completed a comprehensive infection control audit for the whole hospital in August each year. The auditors had assessed Byron Ward as being fully compliant with seven of the ten areas covered in the audit, including hand hygiene. It was partially compliant in the other three areas.
- During the building work, the service was temporarily using a former bedroom as a clinic room. This room was

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

Requires improvement 

used for storing and dispensing medication. This arrangement had begun in May 2017 and was due to last for three months. The room was visibly clean and well organised. Doctors used a separate room to examine patients. This room was equipped with a couch, an electro-cardiogram machine and equipment for taking blood samples.

- The ward was visibly clean. Two housekeepers cleaned the ward each day. Housekeepers signed the daily cleaning checklist to confirm they had completed all their daily tasks.
- All staff carried a personal alarm. When a member of staff activated the device, an alarm would sound across the ward. A control panel on the first floor corridor indicated the location of the activated device. Staff on the ward provided assistance in response to alarms,

Safe staffing

- The ward ensured that safe levels of staffing were maintained at all times. The ward employed 33 substantive members of staff. In June 2017, there was one vacancy. Between March and May 2017, the service had filled 836 shifts with bank or agency staff.
- Between June 2016 and May 2017, the staff sickness rate was 1.8%. This is below the national average of 3 to 4%. During this time, 31% of permanent staff had left the service and been replaced.
- The service calculated the number of staff needed on each shift using a matrix provided by Cygnet Health Care. This meant the number of staff increased according to the number of patients. There were two nurses on duty at all times. This increased to three when there were more than 16 patients. The ward increased the allocation of support workers from one to two when there were more than eight patients. During the day, there were three support workers if there were more than 12 patients. The numbers of nurses matched the required number at all times.
- Between March and May 2017, the ward had used bank staff on 512 occasions. The ward had used agency staff on 324 occasions. This meant that bank and agency staff formed a significant part of the staff allocation, with an average shift including three bank staff and two agency staff. The ward mainly used bank and agency staff to provide enhanced observations.
- The ward manager was able to adjust the staffing levels according to the needs of the patients. This frequently involved allocating additional staff to carry out

enhanced observations. On average, four patients required enhanced one-to-one observations during each shift. This frequently increased to up to ten patients. However, when there were more than six patients requiring enhanced observation, it could be difficult to achieve the full staff quota and provide cover for staff who were taking breaks.

- While staff said they were often stretched, patients had one-to-one time with a named nurse. The service rarely cancelled escorted leave and activities.
- There were sufficient staff on the ward to carry out physical interventions.
- There were two part-time specialty doctors working on the ward, covering 9am to 5pm from Monday to Friday. Outside these hours, there were two on-call doctors allocated to the service. They were able to respond promptly to requests for attendance.
- We received information about compliance with mandatory training for the whole hospital. This showed overall compliance with mandatory training was 81%. Compliance with five of the 28 mandatory courses was between 50% and 56%. These modules were clozapine dose titration, deprivation of liberty safeguards and Mental Capacity Act, equality, diversity and disability, prescription writing and administration standards and rapid tranquilisation. This meant that staff may not have had up to date knowledge of key aspects of service delivery. The hospital was in the process of implementing a new system of training, moving from traditional classroom based training to learning through computer-based courses.

Assessing and managing risk to patients and staff

- Between December 2016 and May 2017 there had been 17 incidents of restraint, involving 12 patients. Two incidents involved patients being restrained in the prone position. Records showed how long prone restraint lasted and provided the names of each member of staff involved.
- We reviewed five patient records. These records showed that staff carried out a risk assessment of each patient when they were admitted. Staff undertook a risk assessment of patients when they arrived at the ward using the short-term assessment of risk and treatability (START) model. Areas of risk identified within this assessment include risk to others, self-harm, and

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

Requires improvement 

unauthorised leave. Staff used the risk assessment to determine the level of observation for patients. Staff regularly reviewed and updated the risk assessment during the admission.

- The service tried to minimise blanket restrictions. Staff completed individual risk assessments of patients before introducing restrictions on leave or placing the patient on enhanced observations.
- The service placed informal patients on constant enhanced observations without ensuring there were sufficient safeguards to prevent the risk of excessive restrictions and de facto detention. While the policy stated that staff must always seek the consent and understanding of the patient being observed, this did not always take place. One informal patient had been subject to this level of observation for more than two weeks. One informal patient said that they had not liked the level of observations and found it intrusive. This level of observation could cause significant restriction on patients and give the impression that they needed permission to exercise their freedom of movement. At a community meeting in May 2017, a patient asked why informal patients could not go out when they wanted to. They were told this would be determined by their clinical team. This statement was misleading and could lead to unlawful restrictions on patients' liberty.
- The ward used enhanced observations extensively to reduce risks of suicide and self-harm. During the inspection, staff were carrying out enhanced observations of between five and seven patients. This meant that a member of staff was with each of these patients at all times. Records showed that the number of patients on this level of observation could rise to 10. Staff recorded the reasons for continuing enhanced observations each day. Staff reviewed the observation level at the handover meeting, and at the weekly ward round. Staff searched patients returning from unescorted leave if they were concerned that the patient may be bringing prohibited items onto the ward.
- Staff recorded incidents of restraint on a designated form. Forms showed the type of restraint. Staff also recorded the reason for the restraint and the attempts they had made to de-escalate the situation before using restraint.
- The provider had a rapid tranquilisation protocol in place. Between December 2016 and May 2017, there had been no incidents of rapid tranquilisation. However, in June 2017, the staff had used rapid tranquilisation

twice. In both instances, staff recorded the patient's vital signs immediately after the administration of the medicine. Staff had recorded further attempts to monitor vital signs but noted the patient was either asleep or had refused.

- Staff on Byron ward were trained in safeguarding and knew how to make a safeguarding alert. Staff had referred one safeguarding concern to the local authority in the six months before the inspection. The ward had implemented a safeguarding plan for this patient. Eighty percent of staff completed training in safeguarding for both adults and children. The hospital had thorough policies and procedures for safeguarding patients. The hospital had appointed the clinical services manager as the professional safeguarding lead. The professional lead provided advice and support to staff whenever there was a concern about safeguarding. Staff gave examples of situations in which they had raised safeguarding concerns.
- Medicines were available at the point of need. All prescribed medicines were available at the service and were stored securely in locked medicines cupboards. Nurses trained in medicines administration administered medicines. The service provided medicines information to patients and their carers. The provider followed current and professional guidance about the management and review of medicines. For example, we saw evidence of several recent checks taking place, including safe storage of medicines, room and fridge temperatures and controlled drugs, on a daily basis. Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities completed by two members of staff.
- The hospital arranged for children to visit patients. Visits did not take place on the ward. Usually, visits took place in a lounge near the hospital reception.

Track record on safety

- There had been two serious incidents on the ward in the 12 months before the inspection. These incidents had been investigated using a structured process.

Reporting incidents and learning from when things go wrong

- Staff recorded incidents in an incident book. Staff completed incident forms thoroughly. Incident reports included incidents of self-harm and aggression.

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

Requires improvement 

- In the three months from April to June 2017, staff had recorded 39 incidents. Staff recorded all incidents. Most records included action relating to the specific patient involved in the incident. For example, action following the incident could be for the patient's observation level to be increased or for the patient to be transferred to a psychiatric intensive care unit.
- Information about incidents were passed on colleagues in handover meetings. However, we did not see any evidence that staff discussed specific incidents in team meetings. This meant that staff who had not been on duty on the day of an incident may not be aware of it.
- Staff held debriefing meetings after incidents and staff were offer support. These debriefing sessions were limited to staff directly involved in the incident.

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

(for example, treatment is effective)

Requires improvement 

Assessment of needs and planning of care

- The ward received referrals from NHS trusts across England. When the service received a referral, a nurse reviewed the information provided to assess whether the patient was suitable for admission. We reviewed six patient records. Staff completed comprehensive assessments when patients were first admitted to the ward. These included a mental state examination, details of the psychiatric history and a physical examination. Most patient records included an assessment of capacity to consent to admission and treatment.
- Patients received a physical examination on admission. Staff routinely carried out physical health checks according to the needs of the patient.
- Staff completed care plans for patients shortly after admission. In some cases, staff wrote the care plan as a specific document while in others the care plan was included in the progress notes. This meant it could be difficult for staff to find the care plan, especially agency staff who may be unfamiliar with the ward. Care plans

written shortly after admission tended to be generic. Staff from all professional disciplines made regular entries in the patient records. All records were up-to-date.

- The service stored information about patients on a paper record. These records were stored in the nurses' office.

Best practice in treatment and care

- The service treated patients with mental illness including depression, schizophrenia and bi-polar disorders. Treatment decisions were based on assessments and investigations. The service provided psychological therapies alongside medicines. Doctors made prescribing decisions based on national guidance.
- In addition to the treatment of mental illness, the service occasionally admitted patients for alcohol detoxification. The service had clear protocols for detoxification. However, the service did not assess of the severity of alcohol dependency or liver function tests prior to commencing treatment. This meant that the starting dose of medicine could be incorrect. In addition, the service did not use any tools to assess the severity of patients' withdrawal from alcohol.
- The service employed therapists with experience in addictions, mindfulness, relationships problems solving and goal setting. Therapists worked with patients in groups and individual sessions. The service provided groups on mindfulness, cognitive behavioural therapy, recovery and psychotherapy.
- Patients had good access to physical health care. Some patients had specific care plans for physical healthcare. One patient had a specific care plan for the management and treatment of diabetes. When patients required inpatient treatment for their physical health they were transferred to the local general hospital.
- Patient records showed that staff used rating scales to assess patient's severity and progress. These scales included Health of the Nation Outcome Scales, General Anxiety Disorder questionnaires (GAD-7) and depression test questionnaires (PHQ-9).
- Specialist staff carried out most audits. For example, the MHA administrator carried out MHA audit, an infection control team conducted the infection control audit and the contract pharmacist carried out medication audits. Ward staff were involved in clinical audits of the management of controlled drugs and clinical records.

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

Requires improvement 

Staff skilled to deliver care

- The multidisciplinary team included two consultants, two specialty doctors, nurses, support workers, a psychotherapist, an occupational therapist, an integrated therapist and two sessional therapists.
- Staff were suitably qualified. Approximately 50% of nursing staff were relatively new to the service having joined within the previous year. Revalidation of doctors was up to date.
- The induction of new staff took place over five days. During the induction, new staff completed a workbook covering the key policies and procedures such as engagement with patients, observation, and health and safety. New staff completed mandatory training online. A preceptorship programme had been established for newly qualified nurses.
- Only 56% of eligible staff (those that had been there more than one year) had received an appraisal in the last 12 months. The manager had completed records for six of the nine appraisals that had taken place. Appraisal records were comprehensive. They provided a record of the competency of the employee. Appraisals had been scheduled for the seven staff who had not been appraised. Data provided by the hospital showed that 91% of staff on Byron ward had achieved the target for supervision. Staff said they regularly received supervision. However, records showed that only one to five people had received supervision each month from January to April 2017. The recording and storage of supervision notes was poorly organised and it was difficult to find specific records. Supervision records we reviewed lacked details of discussions. These records did not include any discussion about the care and treatment of specific patients.
- Staff could request to go on specialist training courses. However, none of the nursing staff had received specialist training on alcohol detoxification. This meant that staff may not have known the risk of fits and delirium tremens, or what to do if a patient's condition deteriorated. Nurses who supervised health care assistants did not receive training in how to conduct supervision sessions.
- The manager addressed poor performance through supervision. A procedure was in place for managers to set objectives for staff they identified as performing poorly. However, this system may be compromised by the inconsistency of supervision.

Multidisciplinary and inter-agency working

- Staff held multidisciplinary team meetings each week. Staff invited patients to attend these meetings to discuss their progress. We observed a meeting attended by the consultant psychiatrist, specialty doctor, two staff nurses and a therapist. All staff contributed to discussions during the meeting.
- Staff held handover meetings twice a day, at the start and end of each shift. Staff had recently started to record handover meetings, although there were only seven records of meetings for the three weeks prior to the inspection. During the handover, staff gave a summary of each patient during the previous shift including their presentation, activities, incidents and observation levels.
- The service maintained relationships with the referring NHS trust to plan arrangements for discharge. The ward manager had a monthly meeting with the Partnership Development Manager to review the relationships between the ward and referring NHS trusts.

Adherence to the MHA and MHA Code of Practice

- An experienced Mental Health Act (MHA) administrator received and examined all statutory documents relating to the MHA.
- The MHA administrator provided to support staff and regularly visited the wards to provide advice. The administrator had a system in place to remind responsible clinicians of the dates for renewals and capacity assessments.
- The ward kept clear records of leave that had been authorised. Responsible clinicians used a standard form to authorise leave for patients. This form includes a record of all episodes of leave that had been taken. The MHA office held letters from the Ministry of Justice authorising leave for restricted patients.
- Training in the MHA and MHA Code of Practice had been completed by 98% of staff. Staff had a good understanding of the MHA and Code of Practice.
- Staff spoke to detained patients about their rights under the MHA and how the MHA applied to them. One record showed this was not repeated after a patient had shown a poor understanding of this information.

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

Requires improvement 

- Statutory documents relating to the detention of patients was completed correctly and up-to-date. Original documents were stored securely in the MHA office. Photocopies of these documents were kept on the patients' records on the ward.
- The MHA administrator conducted an MHA audit of each ward every month. This audit involved a review of the records of three patients selected at random. The review covered statutory documents, assessments of capacity to consent to treatment and records of discussions about patients' rights.
- An Independent Mental Health Advocate (IMHA) visited the ward twice a week. The service gave patients information about the IMHA when they spoke to the patients about their rights.

Good practice in applying the MCA

- Only 50% of staff had completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS).
- At the last inspection in October 2015, we found that assessments of capacity to consent to treatment were not carried out on a regular, systematic basis. During this inspection, we saw these assessments took place in each ward round. Where a patient disagreed with the clinician and had capacity to make this decision, this conversation was recorded clearly in their notes.

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

Good 

Kindness, dignity, respect and support

- Staff demonstrated a positive attitude towards patients. During interviews, staff spoke about patients in a positive and caring manner. We saw that when patients approached staff for assistance they did all they could to respond to patients' needs. During ward rounds, staff were engaging and listened carefully to patients' views.
- Patients' views of the service were positive. Patients spoke positively about the permanent members of staff, describing them as kind, helpful, polite and supportive. However, two patients raised concerns about interactions with agency staff. We raised this with the

ward manager at the time of the inspection. The ward manager agreed to look into the matter. Patients spoke positively about the occupational therapy (OT) staff, describing them as empathic and understanding. Patients said the activities the OT service facilitated were good.

- Staff recognised that it could be difficult to get to know patients who arrived at the hospital from many different parts of the country and stayed on the ward for a short time. However, patients' records showed that staff explored the patient's history and background during an initial interview, enabling them to understand the circumstances surrounding their admission. During ward rounds, staff asked patients about their history and plans for the future in order to better understand their circumstances.

The involvement of people in the care they receive

- When staff admitted patients to the ward, they were shown around the ward and introduced to staff. The service provided a booklet for patients describing the objectives of care and treatment, therapies available and the facilities the ward provided. However, some patients said they found the induction to be insufficient, with staff not telling them who their primary nurse was.
- Patients gave mixed views about their involvement in care planning. Some patients said they had very little involvement, while others said they met with the nurse every week to update care plans. In the ward round, staff ensured that patients were offered choices about therapeutic activities and were involved in decisions about leave. Care plans showed some evidence of patient involvement.
- A local voluntary organisation provided an independent mental health advocacy service (IMHA). An advocate visited the ward twice a week. The advocate said that staff and patients had welcomed the service. The advocate's role included raising concerns on behalf of patients. Recently, most concerns had been about the noise created by ongoing building work at the hospital.
- Active involvement of families and carers was difficult as patients were often a long way from their homes and families. When family members were able to attend, staff invited them to the ward round. The doctor telephoned family members if the patient consented and requested this.

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

Requires improvement 

- Community meetings were held twice a month. Notes of meetings between March and June 2017 showed that between five and nine patients attended. Up to 15 staff also attended. During these meetings, staff informed patients about health and safety matters and provided information about changes to services. Patients made general comments about care. Matters raised by patients were assigned to a member of staff to be addressed. The service displayed notes of meetings on a notice board. Between January and March 2017, only one patient had completed the patient survey. This patient gave positive responses to all the questions. Patients had been involved in the planning and development of a recovery college.

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

Good 

Access and discharge

- Between December 2016 and May 2017, bed occupancy was 76%. This meant that, on average, there were 14 patients on the ward, out of a possible 18. The service responded to referral requests within one hour and could admit patients at short notice.
- The ward provided a national service. The service did not have a catchment area. Many patients were a long way from their homes and families.
- The ward did not admit patients to bedrooms being used by patients on leave.
- The service only moved patients to other wards if this was justified on clinical grounds or if the referring NHS trust recalled the patient to their local area.
- The service discharged patients from the ward at reasonable times of the day. However, transfers back to patients' local hospitals could take place at very short notice.
- The service could transfer patients to psychiatric intensive care units (PICU) if necessary. Sometimes this was delayed, either by difficulties in finding a PICU or

refusal by the referring NHS trust to agree to the transfer. The service managed the risks of accommodating patients needed a PICU by increasing the level of observation.

- Between December 2016 and May 2017, the discharge of one patient had been delayed due to non-clinical reasons. This delay was caused by the commissioning authority being unable to find an alternative placement.
- Care plans for patients under section 3 of the Mental Health Act did not specifically refer to patients' rights to aftercare under section 117 of the Act. This meant that patients may not be aware that authorities in their areas had a duty to provide after-care services when they left hospital.

Facilities promote recovery, comfort and dignity and confidentiality

- The ward had a full range of rooms and equipment to support treatment and care. All patients' bedrooms had en-suite facilities. There was a large, well-equipped room used for group therapy. Patients were using the facilities in this room throughout our inspection.
- The hospital provided quiet areas where patients could meet with visitors.
- Patients could keep their own mobile phones with them and, therefore, could make telephone calls in private. If a patient did not have a mobile phone the ward provided one that could be used in private.
- Patients had access to a small courtyard garden. The hospital had installed a designated covered area in the grounds for patients. Detained patients required authorisation from the responsible clinician to use this facility.
- The hospital had a well-presented dining room where staff and patients ate meals that were cooked on site. Patients said the quality of food was very good. The local authority food standards agency had awarded the service a score of five out of five for food hygiene standards.
- Facilities were available for patients to make hot drinks and snacks.
- Patients could personalise their bedrooms although few chose to do so given admissions to the ward usually only lasted up to two weeks.
- Patients could lock their rooms from the inside. Staff could override this lock if necessary. However, patients could not lock their rooms from the outside. This meant that personal belongings in their rooms were not

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

Requires improvement 

secure. Lockable safes had been installed in patient's wardrobes but staff told us these did not always work. The staff did store a small number of patients' personal items securely in the nurses' office.

- The service provided creative and therapeutic activities throughout the week. This included groups for creative art, cognitive behavioural therapy (CBT), yoga, mindfulness and managing emotions. Staff within the occupational therapy department facilitated activities. Scheduled group activities at the weekends were limited to a cognitive behavioural therapy group on Saturday mornings and watching a film on Saturday and Sunday afternoons.

Meeting the needs of all people who use the service

- The ward was situated on the ground floor, allowing access for people using a wheelchair. However, the ward was not able to admit patients who required specialist facilities such as adapted bathrooms.
- The service routinely provided information about the Mental Health Act to patients in different languages if required. The service could arrange for other information to be translated on request.
- The service provided information on treatment, patient's rights, access to advocacy and making complaints.
- The service used interpreters at ward rounds and other meetings when this was required. Consultants and therapists were from diverse cultural backgrounds including native speakers of Bengali, Polish, Punjabi and Turkish.
- All food was prepared on site. This meant the hospital could meet the dietary requirements of patients' religious and ethnic groups.
- The service had supported patients to attend local churches. The meeting room could be used for spiritual and cultural activities.

Listening to and learning from concerns and complaints

- There had been four complaints in the 12 months prior to the inspection. The clinical services manager had investigated these complaints. Following these investigations, the clinical services managers had not upheld any complaints. None of the complainants had referred the matter to the ombudsman.
- The hospital provided advice to patients on how to complain in the documents that patients' received on

admission. The hospital produced this information in standard and easy read formats. The hospital's complaints policy stated that complaints and compliments should be recorded, but did not specify how concerns should be addressed if they were not considered to be formal complaints. Four of the six patients we spoke with said they had raised concerns about the service but nothing had happened. For example, one patient said they had raised a concern with the nurses after an agency member of staff had ignored them. Other patients said they had raised concerns about the attitude of some staff, staff speaking loudly at night outside patients' bedrooms, staff turning lights on at 6am each morning and staff speaking to patients in a belittling manner. In each case, patients said that nothing happened. The service had investigated patients' concerns about staff sleeping at night. The ward did not have systems in place for recording these concerns. The ward manager said that matters raised by patients were dealt with straight away. However, the lack of any records meant that we could not confirm this. Also, it was not clear whether there were any trends in the concerns raised or whether these matters had been resolved.

- The clinical services manager received all complaints. Records showed that acknowledgements, investigations and letters to complainants were completed within the timescale set out in the policy. Investigations included a review of CCTV footage and interviews with staff. The clinical services manager set out the findings of investigations in the response letter. However, there were no reports of investigations that included lessons learned or action plans to address any errors.

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

Requires improvement 

Vision and Values

- Staff were familiar with the organisations values of helpful, responsible, respectful, honest and empathetic.
- Staff knew who the senior managers were. These managers visited the ward most days. Managers and senior staff from across the hospital held a brief daily

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

Requires improvement 

meeting to update each other on incidents, admissions and other activities. This meeting include staff from the wards, the therapy department, facilities and administration.

Good Governance

- The governance of the hospital was facilitated by the senior management team comprising of the hospital manager, medical director and clinical services manager. The service had established the role of Clinical Quality and Compliance Lead in 2016. Each month, an integrated governance meeting was held alongside a meeting of all heads of department. Consultants and specialty doctors formed a medical advisory committee.
- During the inspection, the hospital was going through a substantial development. Building work was taking place to refurbish the existing wards and create a new ward, due to open by the end of 2017.
- The hospital had governance systems, although there were some weaknesses in the management of the ward. Systems were in place for monitoring and ensuring that the right number staff were present on the wards at all times. Compliance with mandatory training was 81%, however, compliance with some specific courses was below 60%. Managers appraised and supervised employees, although record keeping of these sessions was inconsistent. There were no systems in place to record and monitor concerns raised by staff and patients, other than through formal complaints and grievances. There were effective systems in place to monitor the use of the Mental Health Act. There were systems to ensure compliance with safeguarding requirements, although the level of reporting was low.
- The ward manager said the primary key performance indicators for the ward were to maintain a minimum occupancy level of 16 patients and respond to all referrals within one hour. The ward received reports showing their compliance in relation to these targets.
- The ward manager had the authority to adjust the staffing levels within the parameters of the staffing matrix. The ward manager had some administrative support from the referrals administrator, but acknowledged that some low priority administrative tasks took a long time.
- The hospital had a risk register showing how the hospital would respond if situations arose that could harm staff or patients, or prevent services from being provided. The register covered four areas of risk; suicide

and self-harm, risk of fire, risk of violence and aggression towards staff and a specific risk relating to overgrowth near the car park. In each case, the service had introduced measures that had reduced the level of risk. The register included a list of further actions to reduce these risks, although in some cases these plans appeared out of date. For example, one entry stated that an annual risk assessment had been carried out in May 2015 and further works were planned over the following 12 months.

Leadership, Morale and staff engagement

- The ward manager provided leadership to staff, and was involved in all aspects of service delivery. This included assessment, decisions about admissions, providing care to patients, supervising staff and facilitating team meetings. Some staff were concerned that the number of clinical team leader posts had reduced, creating additional pressure on other staff, in particular, the ward manager.
- The hospital had conducted a staff survey in 2017. Seventy-five staff had responded to the survey. Overall, 85% were positive about working for the service. Staff gave positive responses to questions about understanding the organisation's values and being supported by their managers. The lowest number of positive responses were for questions about pay and development opportunities.
- In the year up to June 2017, the sickness rate was 1.8%. This is below the average for health service of between 3 to 4%.
- None of the staff raised concerns about bullying or harassment.
- Staff were aware of the whistle blowing process and said they were able to raise concerns without fear of victimisation. However, some staff were frustrated that they had raised concerns and nothing had happened. For example, some staff had raised concerns about the requirement to respond to all referrals within one hour and about situations when they need to accept a number of admissions during one shift. Staff said this created a lot of pressure.
- Staff spoke very positively about their experience of working on the ward. A number of staff said they really enjoyed working there. Staff said that morale and the sense of team work was very strong.
- Staff recognised the importance of openness and transparency.






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

Requires improvement 

Commitment to quality improvement and innovation

- Byron Ward is part of the Royal College of Psychiatrists Quality Network.

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement 

Safe and clean environment

- Staff were able to observe all areas of the wards. The entrance to the ward had an air lock. The ward was located across two floors. The nursing office was located on the second floor. On the ground floor, a member of staff was present at all times in the security office. The service did not lock the stairwell between floors and patients had freedom to access both areas. The stairwell had a convex mirror that allowed staff to observe a blind spot around the stairs. The service had installed closed circuit television (CCTV) across both floors. The security nurse monitored this in the security office located near the front of the entrance. To maintain safety, staff kept some rooms locked. For example, staff supervised access to the gym, activity room and sensory room. The ward placed patients assessed as a higher risk on one to one observations in line with their assessed needs.
- The ward had a secure perimeter fence that surrounded the garden. The fence was the required height for the service. However, branches of nearby trees overhung the fence. This meant that patients with unescorted access to garden may have been able to abscond. Staff said they mitigated this risk through the use of CCTV, which the security nurse monitored in the security office, located next to the garden entrance.
- The service managed ligature risks appropriately. The ward conducted an annual ligature audit to identify ligature anchor points across the ward. The service last completed a ligature audit of the environment in March 2017. All bedrooms were fitted with anti-ligature

features such as door hinges, door handles and taps. The ligature audit documented any remaining ligature anchor points. The audit rated the level of risk for each ligature anchor and provided details of how staff mitigated this risk.

- The ward kept ligature cutters in the nursing office. The ward had clearly labelled the location of ligature cutters. Permanent staff gave an induction and tour to agency staff who were unfamiliar with the ward. A bag of emergency equipment was kept in the nurses' office and checked each week.
- There were robust processes in place to store medicines requiring refrigeration. Staff recorded fridge and room temperatures including minimum and maximum temperatures, on a daily basis. On the majority of occasions, the fridge temperature was within the appropriate range of 2-8°C. However, on 14 occasions in May 2017, the temperature had deviated above the maximum temperature by 0.5°C. The ward had been proactive and took actions to prevent this. Staff we spoke with were able to describe the process to reset the fridge in case of temperature reading fluctuations.
- The ward had a fully equipped clinic room. An electrocardiogram (ECG), blood pressure machine, pulse oximeter and blood glucose machine were kept in the clinic room. The ECG machine had last been calibrated six weeks before the inspection. Records showed that other equipment was checked each month, with the last check being carried out three weeks before the inspection.
- The ward had a seclusion room. The seclusion room had toilet facilities, a clock and allowed two-way communication. Staff could see patients through an observation window.

Forensic inpatient/secure wards

- Communal areas across the ward were clean and well maintained. Domestic staff were responsible for general cleaning. We reviewed cleaning records for April, May and June 2017 which showed that the ward and majority of patient bedrooms were cleaned on a daily basis. However, in two bedrooms, we observed cobwebs on the walls, crushed food on the floors, dirty toilets and strong odours. Domestic staff said it was difficult for them to access patients' bedrooms when patients did not want to have their rooms cleaned and when the rooms contained a lot of property. When we raised this with the service, they informed us that they expected staff to support patients to clean their rooms to promote patients' independence.
- The infection control team completed a comprehensive infection control audit for the whole hospital in August each year. The auditors had assessed the Springs Unit as being fully compliant with seven of the ten areas covered in the audit, including hand hygiene.
- The ward stored items that could potentially be hazardous to health, such as detergent and cleaning products appropriately. We observed laundry detergent left in the laundry room. However, staff supervised access to this room. Staff had completed risk assessments for items such as washing up liquid, laundry powder and disinfectant as part of the Control of Substances Hazardous to Health Regulations 2001 (COSHH).
- At a previous inspection in October 2015, we found that areas of the ward were untidy and were not kept clear of broken or unused equipment. At this current inspection, we did not see an improvement. The gym still had broken equipment and the garden was unkempt in areas. The staff break room was used to store items from other wards during on-going building works. Staff informed us that this would change when the building works were completed. The ward manager also confirmed that the hospital manager had agreed to order new gym equipment.
- The service carried out daily assessments to ensure the ward environment was safe. The ward allocated a member of staff as a security lead on each shift. The security lead conducted daily environmental checks. The purpose of this was to review security, damage on

the ward, contraband and ligature points. The environmental security checklist covered areas of the ward such as emergency exits, service user bedrooms and windows, communal areas and the seclusion room.

- The ward issued all staff with a personal alarm. Staff completed daily checks of the staff panic alarms and security radios to ensure they were working.

Safe staffing

- The ward ensured that safe levels of staffing were maintained at all times. The service had an establishment level of 25 staff, consisting of 11 nurses and 14 health care assistants. At the time of our inspection, there were five vacancies for nurses. From June 2016 to June 2017, six staff had left the service, amounting to a high turnover of 32%. This meant that a number of staff were quite new to the ward. The sickness rate was 3%.
- The service operated two shifts each day. During the day, the service allocated seven staff to the ward including at least two qualified nurses. At night, the service allocated four staff, including at least two qualified nurses.
- The service had a high number of shifts filled by bank and agency staff. From March 2017 to May 2017, the service used bank staff to cover 463 shifts and agency staff to cover 634 shifts. This totalled 1097 shifts over a three-month period. No shifts remained unfilled. Bank and agency staff were deployed to support patients requiring enhanced observations.
- Nursing staff were able to book additional bank nurses and health care assistants according to patient need. The service had designated champions for health care assistants who were able to monitor the staff and rota and sometimes book additional staff. The service would allocate additional staff if patients needed increased observation or accompanying to appointments.
- There was a member of staff present in communal areas at all times.
- Three patients and two members of staff said that escorted leave was regularly re-scheduled due to a lack of available staff, particularly if a high number of patients were on enhanced observations.
- Sufficient staff were allocated to the ward to carry out physical interventions. All staff were trained in how to carry out physical intervention.
- Medical cover was available at all times. A ward doctor provided medical cover between 9am and 5pm from

Forensic inpatient/secure wards

Monday to Friday. Outside these hours, a duty doctor was available on-call. This doctor was not based on site, but was required to attend within an hour of being called.

- We received information about compliance with mandatory training for the whole hospital. This showed overall compliance with mandatory training was 81%. Compliance with five of the 28 mandatory courses was between 50% and 56%. These modules were clozapine dose titration, deprivation of liberty safeguards and Mental Capacity Act, equality, diversity and disability, prescription writing and administration standards and rapid tranquilisation. This meant that staff may not have had up to date knowledge of key aspects of service delivery. The hospital was in the process of implementing a new system of training, moving from traditional classroom based training to learning through computer-based courses.

Assessing and managing risk to patients and staff

- Staff undertook detailed risk assessments of patients on admission using a recognised tool, known as the short-term assessment of risk and treatability (START) model. We reviewed five patient records. The risk assessment identified areas of risk including self-harm, triggers and risks to others. Risk assessments were up to date and reviewed regularly at weekly ward rounds as well as, for example, after an incident. Risk assessments included patient views. Where appropriate to the patient, staff also used other risk assessment tools, such as the HCR-20, which is a violence risk assessment tool.
- Staff were aware of and followed the providers observation policy. Staff used four levels of observation. Staff recorded 15 minute intermittent observations for all patients. The frequency of observation increase according to the level of risk the patient presented. Patients who presented a very high risk could be supervised at all time by up to three members of staff. Staff discussed and managed observation at ward rounds and multi-disciplinary meetings.
- The ward had procedures in place to maintain security. The doors to patients' bedrooms could only be locked and unlocked by members of staff. Staff conducted a search of patient's property on admission to the ward and on return from leave. The service did not permit patients to have cigarette lighters, matches, aerosols and razors. The ward had a locked cupboard to store the items that posed a risk. Patients were aware of these procedures and gave consent. However, the provider did not maintain records of room searches. The service expected staff to complete room searches within 20 minutes. This was difficult in some rooms due to the amount of property patients stored there. There was a risk that patients' rooms were not searched appropriately which could compromise patient safety.
- The service audited incidents of restraint, seclusion and use of rapid tranquilisation. The audit was presented at the provider's information governance meeting. The audit was used to evaluate restrictive interventions across the hospital.
- Between December 2016 and April 2017, there were 37 incidents of staff using restraint. These incidents involved nine patients. Records showed that de-escalation was used before the staff used physical restraint. Five of these restraints resulted in the use of the prone position. Four resulted in the use of rapid tranquilisation.
- Between December 2016 and April 2017, four incidents resulted in the use of rapid tranquilisation. We observed that staff recorded physical checks to patients after administering rapid tranquilisation.
- Between December 2016 and April 2017, there were 21 occasions when patients were nursed in seclusion. Each use of seclusion was appropriately authorised by the nurse in charge of the ward and the duty doctor was contacted as soon as possible. Staff recorded observations every 15 minutes. Nursing, medical and multi-disciplinary reviews were appropriately documented.
- Staff demonstrated a good understanding of safeguarding and were trained in safeguarding adults from abuse. Staff were able to give examples of when a safeguarding referral was required, for example, if a patient was at risk of financial, physical or emotional abuse.
- The ward managed medicines well. People received their medicines as prescribed. Medicine administration records showed no gaps in the recording of medicines administered, which provided assurance that people were receiving their medicines safely, consistently and as prescribed. Staff provided medicines information to patients and their carers in easy read formats. Appropriate stocks of prescribed medicines were

Forensic inpatient/secure wards

maintained with robust systems to monitor stock levels and re order required medicines in place. Staff placed medicines to be disposed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection. Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities.

- At our previous inspection in October 2015, we identified that the ward did not have a flumazenil injection available which is used to reverse the sedative effects of benzodiazepines. At this inspection, we identified that the medicine was categorised as not necessary as a stock item of medicine. The provider's policy outlined reasons for why it was not kept as a stock item.
- The hospital had a room located off the ward that patients could use for visits with children.

Track record on safety

- The ward had two serious incidents in the last 12 months that required investigation. These related to a physical assault of a patient by another patient and a patient failing to return from leave. These incidents had been investigated using a structured process.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and what classified as an incident. During the previous inspection in October 2015, we found that some staff were not clear on what constituted a reportable incident and that not all incidents that should be reported were reported. At this inspection staff highlighted appropriate examples of incidents they needed to report and how they would report these.
- All incidents were recorded and reviewed by senior staff. Staff recorded incidents in an incident log book. The ward manager reviewed incident reports and signed them off. The ward manager forwarded the incident to the clinical nursing manager, heads of department and pharmacy if it was a medication incident.
- Staff did not regularly discuss learning and feedback from incidents. Staff told us this occurred in team meetings. However, when we asked for minutes of team meetings over the last six months, the service could only provide minutes for May 2017. The minutes did not demonstrate that there was learning and feedback for incidents.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- Staff conducted comprehensive assessments of patient's mental and physical health on admission. Comprehensive physical assessments were completed within 24 hours of admission. This included a medical history and physical examination, blood tests, measuring vital signs, and assessing general health and lifestyle.
- We reviewed five care records. These were up to date, holistic, personalised and included input from the multi-disciplinary team. Care plans included goals and objectives for staff to support patients with daily tasks such as self-care routines, tidying bedrooms and encouraging personal care.
- Patients had detailed and comprehensive positive behaviour support (PBS) plans. The psychologist led on PBS plans and completed these with the MDT and the patient. PBS plans included patient's aims, needs, triggers, calming techniques, problem behaviours, functions and positive support strategies. Linked to the positive behaviour support plans were communication protocols. The communication protocol covered steps to improve communication, support strategies, language and communication screen and recommendations to develop communication skills, for example, attending sensory sessions.
- Staff assessed patients physical health needs on admission and regularly monitored patient's physical health. Care records documented regular discussions of physical health by the MDT as well as with patients. Patients we spoke with were positive about the support they received for physical health.
- The five care plans we reviewed had evidence of discharge planning for patients. Staff discussed discharge planning at care and treatment reviews as well as at ward rounds. Minutes of care plan reviews demonstrated discussion with commissioners about patients' progress and plans for step down treatment or discharge. Care plans discussed future planning

Forensic inpatient/secure wards

objectives and steps to prepare patients for discharge. This included how patients would manage tasks in the community, such as preparing meals and washing their own clothes.

- In October 2015, we found that staff found it difficult to locate information on the paper files. At this inspection, information was easily accessible. Staff documented care records on paper and stored them in the nursing office. The service also had a shared drive with an electronic system where all members of staff could upload information.

Best practice in treatment and care

- There was evidence that staff followed National Institute of Health and Care Excellence (NICE) guidance when prescribing medication.
- The service had a part time psychologist who was assisted by three assistant psychologists. The service offered psychological therapies recommended by NICE guidance. This included cognitive behavioural therapy, dialectical behavioural therapy and trans-diagnostic behaviour therapy. All patients received weekly psychological therapy.
- The occupational therapist conducted occupational self-assessments and model of human occupation screening tool (MOHOST) for patients. They completed initial assessments of patient's speech and language, awareness of road safety, kitchen assessments and sensory assessments.
- Staff registered patients with the local GP on admission. The ward doctor took patients vital signs on a weekly basis and assessed patients' general health. Staff supported patients to attend GP, dental and specialist appointments.
- Staff used rating scales to assess and record severity and outcomes for patients. Staff used the Health of the Nation Outcome Scales (HoNOS) to measure outcomes. These scales covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions.
- As part of the hospitals quality improvement plan, the service had developed corporate and local clinical audits. These included audits covered the use of CCTV, infection control, physical healthcare, engagement and use of restraint. The ward manager and head of

department were required to review audits and implement actions. However, we saw little evidence of completed audits and staff told us that they had only recently been implemented.

Skilled staff to deliver care

- The ward had a full range of mental health disciplines that provided input to the service. This included nurses, nursing assistants, a consultant psychiatrist, psychologists, assistant psychologists, an occupational therapist and an occupational therapist assistant.
- At our previous inspection in October 2015, we identified that staff had received limited specialist training in learning disabilities (LD), autistic spectrum disorder (ASD) and autism. At this current inspection, this had improved. Staff were knowledgeable and had received internal and external training relating to autism and learning disabilities. To support agency staff without a background in ASD or LD, the service used agency staff who were familiar with the ward. The provider was planning to introduce training for long term agency staff. Staff discussed cases on an individual basis and used less agency staff at night.
- New staff received a full induction to the ward. Staff met with security and staff, toured the hospital and discussed conduct with ward managers. New staff were given a diary to complete for the first week of employment to reflect on their experience. Staff were supernumerary for their first week to allow time for them to work closely alongside experienced colleagues. Staff induction also included training on the organisation's policies.
- The ward had a supervision target of 90%. From June 2016 to May 2017, information provided by the service demonstrated that 88% of staff had received supervision on a monthly basis. Supervision records we reviewed addressed record keeping, training, professional development and workloads. However, during our inspection, we found it difficult to obtain supervision records and were only able to view six records in total.
- Staff met for team meetings on a monthly basis.
- Appraisal rates at the service were low. At the time of our inspection, 68% of staff had received an appraisal.

Forensic inpatient/secure wards

- The consultant psychiatrist had been revalidated in the last 12 months. Revalidation involves confirmation by General Medical Council that a doctor can continue to practice.

Multidisciplinary and inter-agency team work

- The service held a multi-disciplinary ward round on a weekly basis. We observed a ward round and saw staff had detailed and informative discussions with patients. The ward round had good multi-disciplinary input from all professions.
- The ward held three handover meetings daily to share information. The morning and evening handovers were attended by nurses and health care assistants. Psychologists, occupational therapists, nursing staff and the ward doctor attended a handover at 9am.
- The provider worked closely with external organisations, such as the police and local authorities. Staff invited representatives from appropriate stakeholder organisations to care review meetings. Staff reported positive working relationships with partner organisations.

Adherence to the MHA and the MHA Code of Practice

- Training in the MHA and MHA Code of Practice had been completed by 98% of staff.
- MHA documentation was stored in paper files. There were records of leave arrangements, relevant capacity assessments and detention paperwork. The ward had attached consent and authorisation certificates to patients' medicine charts.
- Staff informed patients of their rights. Care plans demonstrated that staff regularly reviewed patients' rights with them.
- The ward displayed information about independent mental health advocates (IMHA) who attended the ward on a weekly basis.
- Staff knew who to contact for advice on the MHA. The hospital had a MHA office and staff could access this for administrative support and legal advice where necessary.

Good practice in applying the MCA

- Fifty per cent of staff had completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS).

- At our previous inspection in October 2015, we identified that it was not always clear how staff were supporting patients to make relevant decisions and staff had not always recorded that they had assessed an individual's capacity to make a decision when it had been necessary to do so. At this inspection, we observed that the MDT reviewed issues relating to capacity at ward rounds. Where decision specific capacity assessments had been completed, these were recorded in care records.

Are forensic inpatient/secure wards caring?

Good 

Kindness, dignity, respect and support

- We observed caring and respectful behaviour from staff when interacting with patients. Staff were responsive and flexible in responding to patients individual needs.
- We spoke with five patients and received two comment cards. Both comment card responses were positive. Patients we spoke with were positive about staff on the ward. Patients highlighted that staff were caring, respectful and that the ward was homely, if slightly hectic. Patients did note that they preferred permanent staff to agency staff, some of whom they felt were not as polite or aware of their needs.

The involvement of people in the care they receive

- The ward gave patients an information pack on admission. This informed patients about the ward, for example, meal times, activities and the staff team.
- Records showed patient involvement in care and treatment. Patients and staff reviewed care plans on a regular basis. Care plans included patient views on goals and objectives. Patients signed their individual care plans.
- Staff could clearly describe the role of an advocate. Patients were aware of who this was and said they spoke with them when they were on the ward. An advocate is someone independent of the hospital who can support them to raise concerns and make choices about their care.

Forensic inpatient/secure wards

- Records contained documents showing whether patients consented to information being shared with agencies or family members. This was reviewed and signed by patients every six months.
- Patients were positive about the weekly ward rounds. Patients said it was a good opportunity to have their opinions heard and discuss their care and treatment with the multi-disciplinary team.
- The ward held weekly community meetings. Minutes of these meetings were displayed on notice boards in communal areas.
- Patients had the opportunity to give feedback through a patient satisfaction questionnaire. Between January 2017 and March 2017, six patients had completed this survey. Respondents said they felt safe, that the service supported them to contact family members, that they felt better since admission and knew how to make a complaint. However, patients did not feel there were enough activities at night and at weekends. Patients had been involved in the planning and development of a recovery college.

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

Good 

Access and discharge

- The service admitted patients from across the country and responded to requests for pre-admission assessments within five days. Referrals came from families, local authorities and prison services. When the service received a referral, they conducted a pre admission assessment in regards to the patient's suitability for the service. This included assessments of the patient's autistic spectrum disorder or learning disability.
- From December 2016 to May 2017, average bed occupancy was 94%.
- The service planned all admissions and discharges. Admissions and discharges took place at an appropriate time of the day.
- Patients always had access to a bed when they returned from leave.

- The average length of stay for patients discharged within the last 12 months was 552 days. For current patients the average length of stay was 420 days. Between December 2016 and May 2017, the ward had not experienced any delayed discharges.

The facilities promote recovery, comfort and dignity and confidentiality

- A patient gave us a tour of the ward during our inspection. The ward consisted of two floors and had a full range of rooms and equipment to support treatment and care. This included two communal lounges located on each floor, a sensory room, a communal bathroom, a kitchen and a gym/pool room.
- At our previous inspection in October 2015, we identified that the ward was not autism friendly. The ward did not have visual signs and support to help people around the ward and staff found it difficult to support some patients with autism spectrum disorder because the layout of the ward made it difficult to reduce noise. At this inspection, we identified that this had partially improved. The ward had made some improvements to making the environment more autism friendly. For example, the recruitment of an artist who spent time with patients to gather their opinions on how they felt the ward should look, notice boards were in easy read formats and staff gave patients ear defenders to reduce noise. Staff we spoke with felt patients were mostly high functioning and felt visual signage could be detrimental and over stimulating.
- At our previous inspection in October 2015, we found that patients' confidential patient information displayed in the nursing office could be seen by patients and visitors. At this inspection, we identified that this was no longer possible as doors had been fitted to the board which were kept closed.
- Patients could access quiet areas such as the sensory room. The sensory room had mood lighting and soft furnishings. The first floor had a designated meeting room where patients could meet visitors.
- Patients were able to access mobile phones supplied by the ward to make personal phone calls in private.
- Patients had unrestricted access to a garden. The garden was large and had space for activities.
- Patients we spoke with were positive about the food. Patients highlighted meal times were consistent and the menu was not repetitive.

Forensic inpatient/secure wards

- Patients were able to make hot drinks and snacks whenever they wished. Patients were able to keep snacks in their bedrooms.
- Patients were able to personalise their bedrooms and bring their own belongings, such as tablets or a television.
- Patients could store possessions securely in a locked cupboard.
- The ward provided a range of activities to patients each day. The ward displayed the activity timetable on the notice board. Activities included a football club, swimming, walking groups and café social groups.
- The service operated a recovery college for patients to attend. An English tutor came in once a week to support patients. The service had recently recruited a member of staff with a teaching background who would work with the occupational therapy team. Some patients were able to take up therapeutic jobs on the ward. One patient presented a session on understanding autism with the psychologist to staff and was paid for their service. The ward also paid patients who helped in the garden.

Meeting the needs of all people who use the service

- The ward was located across two floors and had a lift to ensure access for people with mobility issues.
- The service displayed information on patients' rights, local services and making complaints.
- The ward did not display information leaflets in other languages. At the time of this inspection, all patients' first language was English. The manager could request leaflets in other languages if needed.
- Staff could book interpreting services if required.
- The ward provided food that met religious needs, such as kosher or halal.
- Patients had access to a spiritual and faith room. Patients said staff supported them with their religious beliefs and accompanied them to places of religious worship when they wished. If requested, a chaplain visited the ward.

Listening to and learning from concerns and complaints

- Patients we spoke with knew how to make a complaint both formally and informally. However, one patient said

they had made a complaint and felt that the service had not investigated this. We observed the letter of complaint in the patients care records but did not see any evidence that the complaint had been addressed.

- Staff we spoke with were able to describe the provider's complaint process and that the majority of complaints were addressed informally in ward rounds. The service had not received any formal complaints in the previous 12 months.
- Staff were unsure of who monitored complaints and who managed the complaints log. When we spoke with staff about this they gave different answers and we could not locate a complaints folder for the ward.

Are forensic inpatient/secure wards well-led?

Requires improvement 

Vision and values

- Staff were familiar with the organisations values of helpful, responsible, respectful, honest and empathetic.
- Staff knew who the senior managers in the organisation were and they visited the ward often.

Good governance

- The governance of the hospital was facilitated by the senior management team comprising of the hospital manager, medical director and clinical services manager. The service had established the role of Clinical Quality and Compliance Lead in 2016. Each month, an integrated governance meeting was held alongside a meeting of all heads of department. Consultants and specialty doctors formed a medical advisory committee.
- There were some weakness in the management and governance of the ward. Staff did not maintain records of security searches of patients' bedrooms. Supervision records were difficult to locate and did not contain records for all staff. We received mixed responses from staff in regards to handling complaints and where records of complaints were stored. Appraisal rates were low at 68%. Compliance with mandatory training was 81%, although compliance with some specific courses was below 60%. Systems were in place for monitoring and ensuring that the right number staff were present on the wards at all times.

Forensic inpatient/secure wards

- The ward manager had sufficient authority to manage the ward effectively.
- The provider introduced ward manager reports in November 2016 to provide ward managers with important information about the running of the ward. For example, supervision and appraisal rates, audit outcomes and incident reporting.
- The hospital had a risk register showing how the hospital would respond if situations arose that could harm staff or patients, or prevent services from being provided. However, none of the staff on the ward were aware of this. Staff did have the opportunity to raise concerns for inclusion on the risk register.
- During the inspection, the hospital was going through a substantial development. Building work was taking place to refurbish the existing wards and create a new ward, due to open by the end of 2017.

Leadership, morale and staff engagement

- An experienced ward manager provided leadership. The ward manager knew the staff and patients very well. Staff said the ward had a teamwork ethos and senior staff supported them. The ward had good staff morale and staff spoke positively about their work.






- Staff sickness for the service was 3.2% over the previous 12 months. However, staff turnover was high at 32.4%.
- Staff we spoke with had not experienced any issues of bullying or harassment
- Staff felt able to raise concerns without fear of reprisal or victimisation. All staff we spoke with were aware of how to use the whistleblowing process.
- The provider carried out annual staff surveys. For 2017, 75 members of staff responded to the survey. The survey gave an overall positive score of 73%. Positive factors included managers treating staff with respect, staff enjoyed working for the company, low experience of bullying and encouragement to report errors. Negative factors related to staffing, fair pay and development opportunities.

Commitment to quality improvement and innovation

- The ward is a member of the Royal College of Psychiatry Quality Network for forensic mental health services.

Long stay/rehabilitation mental health wards for working age adults

Good 

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

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

Good 

Safe and clean environment

- The ward was set out over two floors. The layout on each floor meant staff could observe most communal areas of the ward. Staff completed individual risk assessments for patients and at the time of our inspection, no patients were assessed as needing enhanced observations. There was CCTV in communal areas for staff to use if necessary. Patient were aware of CCTV being used and signed a document giving their consent.
- At the last inspection in October 2015, we found that Springs Wing was accessed through another ward. This was a potential risk and disruptive to patients. Since the previous inspection the provider had completed building works and during this inspection, we saw that Springs Wing had been relocated and was now served by its own entrance.. At the last inspection, we also found shower cubicles in ensuite bathrooms were too small for some patients to fit in and therefore potentially unsafe. As a result of building works during this inspection, we saw that patients now had wet rooms that were of an adequate size.
- Staff assessed the environment for ligatures annually and mitigated any identified risks through general observation and individual patient risk assessments.
- Staff stored an emergency equipment bag in the nursing office on the ground floor and had signs to indicate its location throughout the ward. It contained appropriate equipment, such as oxygen, and staff regularly checked and recorded that this was in functioning order. However, the contents of the emergency bag were not organised well, meaning items could be hard to find in a hurry. If needed, staff access a defibrillator from an adjoining ward without delay.
- There was a first aid kit in the nursing office that contained the appropriate equipment that was in date.
- Staff kept ligature cutters in view in the nursing office and labelled them clearly to indicate their location. The ward manager planned to purchase a second pair for the first floor, so staff could access this quickly in an emergency.
- There was a clinic room on the ward where medicines were stored securely and at appropriate temperatures. There was a copy of the current British National Formulary available for staff to reference if needed and pharmacy contact details on display. A box for the safe disposal of needles was appropriately labelled and signed. We found bandages and saline plasters in the clinic room that expired in 2013 and 2015.
- Staff routinely checked the weighing scales and glucose monitoring machine when they were used. Staff would replace these machines if any problems occurred. Staff cleaned physical health equipment after each use and once a week as standard.
- There was no seclusion room on the ward. If seclusion was required, staff accessed a separate facility on the hospital site. There were no recorded incidents of seclusion in the 12 months before the inspection.

Long stay/rehabilitation mental health wards for working age adults

Good 

- We observed that ward areas were visibly clean, had good furnishings and were well-maintained. Patients said the environment was kept clean.
- At the last inspection in October 2015, we found evidence that not all staff followed hand hygiene procedures. During this inspection, we found this was no longer a concern. The provider carried out a hand hygiene audit in August 2016, which found high rates of compliance. There was information about infection control standards and signs about handwashing techniques in clinical and bathroom areas.
- There was evidence of portable appliance safety testing being carried out on electrical equipment in February 2017.
- Community meeting minutes showed staff reminded patients of the fire evacuation procedure each week.
- Staff had access to an appropriate nurse call system to request assistance if needed. Patients could access wall-mounted alarms in all rooms.

Safe staffing

- The provider planned the number and grade of staff required on the ward to ensure patients were cared for safely. Three staff worked during the day and two at night. There was always one qualified nurse on duty. Staff confirmed that when the nurse had a break, they would hand the keys to the clinic room to a nurse on another ward on site.
- Staff rotas showed that the number of staff required to be on shift were on shift. There were nine permanent staff. There were no vacancies for nursing or healthcare assistant staff.
- Patients were aware of how many staff worked on the ward and said that activities were not cancelled because of too few staff. This had improved since the last inspection in October 2015.
- The ward did not use agency staff. Some permanent staff chose to work bank shifts, which are extra shifts on top of their contracted hours. Between March 2017 and May 2017, bank staff covered one-third of all shifts. If necessary, the ward manager was able to adjust staffing levels to take account of case mix and patient need.
- Patients had regular one-to-one time with staff. Between April and June 2017, four of the five care records we examined, showed between one and seven one-to-one sessions per month between named nurses

and patients. One patient's records indicated they had not had a one-to-one session since February 2017. The ward manager said the system for recording these was not well embedded and did not accurately reflect when one-to-one's took place. This was an area they planned to improve.

- All staff were trained in how to carry out physical intervention. Reports showed that staff used de-escalation techniques before using physical restraint. There were three incidents of physical intervention in the six months leading up to the inspection. None of these involved face down, prone restraint. Incident reports included the necessary details of the intervention, such as how many staff were involved, what position they held and how long the intervention lasted.
- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.
- We received information about compliance with mandatory training for the whole hospital. This showed overall compliance with mandatory training was 81%. Compliance with five of the 28 mandatory courses was between 50% and 56%. These modules were clozapine dose titration, deprivation of liberty safeguards and Mental Capacity Act, equality, diversity and disability, prescription writing and administration standards and rapid tranquilisation. This meant that staff may not have had up to date knowledge of key aspects of service delivery. The hospital was in the process of implementing a new system of training, moving from traditional classroom based training to learning through computer-based courses.

Assessing and managing risk to patients and staff

- We looked at five patient records. These records showed staff used a recognised risk assessment tool (short-term assessment of risk and treatability (START)) with every patient on the day of admission and reviewed this as their needs changed, or at least every three to six months, depending on identified risks. Where appropriate to the patient, staff also used other risk assessment tools, such as the HCR-20, which is a violence risk assessment tool.

Long stay/rehabilitation mental health wards for working age adults

Good 

- Staff conducted searches of patient's bedrooms. Staff meeting minutes from March 2017 showed staff discussed introducing random rather than regular and planned searches of patients and their rooms.
- The ward was locked at all times. Informal patients had to ask staff for permission to leave the ward. The ward notice board had clear information on what to do for informal patients who wished to leave the ward.
- There had been no incidents of rapid tranquilisation in the 12 months before the inspection.
- Staff received training in safeguarding and could describe how they would act on a safeguarding concern.
- There was good medicines management practice. People received their medicines as prescribed. Medicine administration records showed no gaps in the recording of medicines administered, which provided assurance that people were receiving their medicines safely, consistently and as prescribed. Staff could provide medicines information to patients and their carers in easy read leaflets for psychotropic medicines through the pharmacy.
- The hospital arranged for children to visit patients. Visits did not take place on the ward. Usually, visits took place in a lounge near the hospital reception.
- The ward did not operate a robust system to protect patients on leave from the ward. Staff used three separate documents to record patient leave. We saw that some forms were missing required information. For example, on some forms there were no details of patient's scheduled return time, a thorough description of clothing or a staff signature. This meant that there could be unnecessary delays in ensuring the safety of patients who did not return from leave when expected. On one leave record, there was no pre-leave assessment recorded for two days in June 2017. The absence of this assessment meant there was a risk the patient may have been in a distressed state while on leave, without the appropriate support from staff.

Track record on safety

- There were no serious incidents in the 12 months leading up to the inspection.

Reporting incidents and learning from when things go wrong

- Staff reported incidents using a paper record system. Staff were aware of how to do this and kept the incident

book in a clear location in the nursing office. The ward manager was able to demonstrate the process of what to do should a medicines related incident or near miss occur. Staff reported 13 incidents since January 2017.

- Records showed staff reported incidents when they occurred and updated risk assessments accordingly.
- Staff said they were offered a debriefing session after incidents took place. Incident records included details of debriefing sessions.

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

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- We reviewed five patient's records. These records showed staff completed an assessment of patients' needs within 24 hours of admission. They also carried out pre admission assessments to judge the suitability of the placement. Records showed that staff considered discharge from the start of admission.
- Occupational therapy staff also carried out assessments with each patient after their admission. This included an assessment of their skills and interests and a risk assessment for using the kitchen to prepare their own food.
- Staff assessed the physical health needs of patients on admission and kept records of ongoing monitoring and support of physical health needs. However, staff did not always carry out tasks in a timely way. For example, for one patient who required weekly physical health intervention, between January 2017 and June 2017, there were nine occasions where there was a gap of over seven days for this intervention to be administered. This could be a risk to the health of this patient. For another patient, between April and June 2017, there were five occasions where staff did not record necessary physical health monitoring information. This was always on a Saturday or Sunday. There was no evidence that staff audited physical health monitoring information.

Long stay/rehabilitation mental health wards for working age adults

Good 

- Each patient had several care plans that related to individual needs, such as mental health recovery, staying healthy and stopping problem behaviours. Each care plan was developed from an assessment of needs. For example, life skills care plans were linked to recovery star assessments. Staff and patients signed that they reviewed care plans regularly. Records showed this was between every two to seven months. Staff kept daily progress notes in the patient's files and related patient progress to their individual care plans. Progress notes were legible and appropriately signed, timed and dated by staff.
- The paper care records we looked at were generally in good order and up to date. However, three of five files contained errors in filing or information. For example, for one patient, two forms (the START risk assessment and the psychiatric assessment) stated an incorrect date for the patient's admission. For another patient, there was no date on their admission form and the psychiatric assessment had a future date recorded. For a third patient, their START risk assessment was not stored in the correct place in their file. This meant staff may not be able to locate it to get information they need in a timely way, which could be a risk to patient and staff safety.
- Staff assessed and supported the communication needs of patients. Two of five patients had communication passports in their files which were completed thoroughly and in the patient's own words. Where patients had specific communication needs, care plans identified how staff should support the patient to communicate. For example, if a patient became distressed and was not able to communicate verbally, staff encouraged them to communicate in writing. Records showed one patient also had a sensory assessment.
- Care plans outlined the individual goals for patients during their stay and after admission in terms of rehabilitation and integration into the community. For example, gaining independent living skills, volunteer job roles and going to college. These goals were written in the patient's own words. There were no patients accessing college or working in volunteer roles at the time of the inspection.

- Staff kept paper records in lockable storage. Older information was archived in the ward manager's office on the first floor. Current information was kept in the nursing office, where all staff could access it.

Best practice in treatment and care

- Medicine prescription charts and discussions with medical staff indicated that that staff followed national guidance when prescribing medication. Patients were not prescribed high doses of antipsychotic medicines.
- Staff were aware of recommended guidelines around therapies and psychosocial interventions. Care records showed evidence that staff and patients considered and discussed leisure activities, help with day-to-day living activities and support in getting a job, which are all activities outlined in the National Institute for Health and Care Excellence (NICE) guidance. For one patient's care plan, staff specifically noted it was developed in line with these guidelines. Each patient received weekly psychological therapy.
- Also in line with NICE guidance, staff supported patients to develop their social skills. For example, through group-based social learning and making clear rules for the ward. During the inspection, we saw staff giving clear feedback to patients about appropriate social interaction and skills.
- All patients were registered with a local GP as part of their admission. Patients could describe what routine physical healthcare monitoring they had. Assessment records were detailed and showed patients accessed appropriate external services for support for their physical health needs. There was evidence in case notes of dental and optician appointments and intervention where needed.
- Staff used rating scales to assess and record severity and outcomes for patients. In one record we saw staff used the Model of Human Occupation Screening Tool (MOHOST). In others we saw staff used the recovery star model and Beck's Depression Inventory where appropriate.
- Although we saw evidence the provider carried out medicines audits, such as safe storage of medicines, room and fridge temperatures and controlled drugs management, we did not see evidence of any other clinical audits. For example, audits on risk assessments, care plans and physical healthcare. Staff said this was

Long stay/rehabilitation mental health wards for working age adults

Good 

an area for development and an annual audit plan was developed in the weeks before the inspection. This was to ensure all wards on the hospital site were carrying out regular and consistent audits.

Skilled staff to deliver care

- A range of mental health professionals worked on the ward delivering appropriate care and treatment. This included nurses, healthcare assistants, a consultant psychiatrist, an occupational therapist and a clinical psychologist.
- Staff turnover was low, with one staff member leaving in the last 12 months. Staff had received training in autistic spectrum disorder since the last inspection. Staff received an induction to the service before they started working on the ward, which included a period of shadowing more experienced staff.
- Although some supervision was taking place, records were sometimes brief and did not always include details of how staff were supported to develop their clinical practice. There were supervision records on the ward for six of nine staff members. Some staff said they kept their supervision records at home as all staff had a key to access the secured cabinet where they were kept. The ward manager had requested for the lock to be changed and was waiting for this to take place. The available records showed that five staff received supervision three times in the six months before the inspection. One had received this once. There were no records of supervision for three members of staff.
- The ward had team meetings every four to six weeks. There were three sets of team meeting minutes available for the five months before the inspection.
- Information provided by the service showed that appraisal rates were 75%.
- The consultant psychiatrist had been revalidated in the last 12 months. This is where the General Medical Council confirms a doctor can continue to practice.
- There were processes in place for management staff to address poor performance appropriately.

Multi-disciplinary and inter-agency team work

- Ward rounds took place each week where staff would discuss patient care. Patients could attend part of this to be involved in decisions.

- The ward manager identified that reflective multidisciplinary meetings did not take place as often as they should and had plans in place to re-introduce these on a monthly basis.
- Between each shift staff had a handover where they shared important updates from the day or night. Staff kept records of these handovers in the nursing office.
- The provider worked closely with external organisations, such as community services, the Ministry of Justice and local authorities. We saw representatives from external organisations were invited to care review meetings. Staff reported positive working relationships with partner organisations.

Adherence to the MHA and the MHA Code of Practice

- Training in the MHA and MHA Code of Practice had been completed by 98% of staff.
- Copies of consent to treatment forms were attached to medicines charts where applicable.
- Staff explained patients' rights under the MHA to them on admission and regularly thereafter. The admissions checklist included this task ward round minutes showed this was considered where applicable. Patients said staff read them their rights monthly. Staff recorded when this took place in daily progress notes and on a specific form.
- This form included a rating for how well the patient understood the information at the time, indicating whether this should be repeated more frequently.
- The hospital had a MHA office and staff could access this for administrative support and legal advice where necessary.
- We looked at the detention paperwork for three patients. Paperwork was filled in correctly and stored appropriately.
- There was information on the ward about what an independent mental health advocate was and that they would visit weekly. This is someone independent of the hospital who can support a patient to understand their rights, support them to raise concerns and be involved in care.

Good practice in applying the MCA

Long stay/rehabilitation mental health wards for working age adults

Good 

- Fifty per cent of staff had completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS).
- At the time of the inspection, one patient had moved from being on a Deprivation of Liberty Safeguard (DoLS) to being detained under the MHA. The paperwork was stored correctly and up to date.
- At the last inspection in in October 2015, we found that assessments of capacity to consent to treatment were not carried out on a regular, systematic basis. During this inspection we saw these took place and staff discussed and considered this in each ward round. Patient files each had a weekly updated sheet to indicate the most recent MDT discussion about the patient's capacity to consent to treatment and other specific decisions. Where a patient disagreed with the clinician and had capacity to make this decision, the conversation was recorded clearly in their notes.
- Most staff were able to describe when capacity assessments would be carried out and the common situations where a patient's capacity was queried.
- We saw staff had queried a patient's capacity to make a decision about finances and applied for an assessment from the local authority.
- Records showed staff and patients reviewed care plans at regular intervals and patients signed their records to confirm they agreed with any changes or plans to continue with the outlined care. Staff did not routinely provide patients with copies of their care plans, but patients we spoke with knew about their care and who to speak to about changes. One patient who was ready to be discharged said staff involved them in discharge planning.
- Care plans included feedback and opinions of patients and carers where appropriate. Several records showed care plans and other documents, such as communication passports, where were written in the first person.
- Staff could clearly describe the role of an advocate. Patients were aware of who this was and said they spoke with them when they were on the ward. An advocate is someone independent of the hospital who can support them to raise concerns and make choices about their care.
- Records contained documents showing whether patients consented to information being shared with agencies or family members. This was reviewed and signed by patients every six months.
- Patients said they felt able to speak to staff about any concerns they had and could raise issues. This could be done through one-to-one sessions, the complaints process or community meetings. The ward had a weekly community meeting where patients could set the agenda for what was discussed. Staff attached the minutes from the most recent meetings to the ward notice board for all patients and staff to see. Patients had been involved in the planning and development of a recovery college.

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

Good 

Kindness, dignity, respect and support

- We observed positive and supportive interactions between staff and patients throughout the inspection. Patients were able to approach staff about their needs and staff appeared to know patients well.
- Patients said staff were polite and were interested in caring for patients. Patients said they knew who their named nurse was but could also approach other staff to speak with. They said staff addressed things that they brought up in one-to-one sessions and felt very able to speak to staff about any concerns they had.

The involvement of people in the care they receive

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

Good 

Access and discharge

Long stay/rehabilitation mental health wards for working age adults

Good 

- Between December 2016 and May 2017, the service reported a 97% occupancy rate.
- Average length of stay in the 12 months before the inspection was just over 16 months. This was reduced from an average of 24 months at our last inspection in October 2015. The average length of stay for the patients on the ward at the time of the inspection was six months.
- Patients always had access to a bed when they returned from leave.
- One patient on the ward was ready to be discharged and staff were in the process of arranging the transfer to an agreed placement.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a range of rooms to support the care and treatment of patients. This included a lounge and kitchen, a quiet room, toilets and individual bedrooms with ensuite facilities. The ward had a communal bathroom with a bath that patients could request to access. The ward manager said this was helpful for patients who were sensitive to showers. There was wifi that patients could use to access the internet on their personal mobile phones. Patients could meet visitors in the quiet room, in their bedrooms or in other rooms on the hospital site.
- Patients could access their bedrooms and bathrooms at any time as they carried keys to open the doors.
- Since the relocation to the new ward, one patient said they could sleep better. However, they said they were still woken up each hour by the night staff torches when they did their observations.
- Patients had access to their own mobile phones if they wished to use them and could make phone calls in private. Staff supported patients who did not have a phone to use the cordless ward phone.
- Patients could access fresh air and outside space. During the inspection, we saw staff facilitate this for patients who required an escort on the hospital grounds.
- Patients could access the kitchen at all times and used it with the OT to prepare meals during the week. Patients were offered the choice to make their own lunch and dinner or eat at the hospital restaurant. The kitchen was equipped with items to support cooking. The OT staff

- did a personal risk assessment with each patient before they cooked on their own. Sharp items such as knives were kept in the nursing office and risk assessed patients could request these when they needed them.
- Patients said the food at the restaurant was fresh and always hot. They said it was positive that they could choose from options. The OT staff encouraged patients to develop their independent cooking skills. For example, through visiting the local library, finding recipes, buying ingredients from the shop or online and cooking the meal.
- Patients could personalise their bedrooms and bring their own belongings. Patients said their belongings were safe in bedrooms.
- Each patient had a weekly timetable for activities, both on and off the ward. These were related to psychosocial care plans and personal interests.

Meeting the needs of all people who use the service

- The ward and its facilities were accessible to people with limited mobility. One bedroom on the ground floor had an accessible bathroom and could be used by someone in a wheelchair.
- All information on the ward was in English. This was the first language of all the patients on the ward at the time. The service could use interpreters if necessary.
- There was a range of information on the ward notice boards. For example, about how to complain, physical health conditions and mutual expectations about the behaviour of patients on the ward. These were not available in easy read formats, but staff said they would provide this if needed. The welcome pack for the ward was available in an easy read format.
- Catering staff said they were able to meet the dietary requirements of religious groups, and were aware of how to do this.
- Staff supported patients to access spiritual support. There was a multi-faith room on the hospital site, although it was not currently accessible due to building work. Patients we spoke with were able to visit their place of worship when they wanted to.

Listening to and learning from concerns and complaints

- Patients said that they knew how to complain, both formally and informally. Patients we spoke with had

Long stay/rehabilitation mental health wards for working age adults

Good 

successfully used the informal process to raise issues. For example, one patient used the internet to contact the hospital via email when raising concerns about their care, so they could keep their own record of all contact and responses. Staff did not keep records of informal complaints, but the ward manager said they planned to start this.

- Staff could describe the complaints procedure and the timeframe of required responses. The ward manager said most feedback received was not in the form of a formal complaint and was dealt with by the staff on the ward immediately. The ward had not received any formal complaints in the 12 months before the inspection.
- The provider had a system to collect compliments and Springs Wing received two compliments in the 12 months before the inspection.

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

Good 

Vision and values

- Staff worked in line with the organisation's values of being helpful, responsible, respectful, honest and empathetic.
- Staff knew who the most senior managers were and said they felt able to speak freely with them.

Good governance

- The governance of the hospital was facilitated by the senior management team comprising of the hospital manager, medical director and clinical services manager. Each month, an integrated governance meeting was held alongside a meeting of all heads of department. Consultants and specialty doctors formed a medical advisory committee.
- During the inspection, the hospital was going through a substantial development. Building work was taking place to refurbish the existing wards and create a new ward, due to open by the end of 2017.
- The ward had governance systems, although there were some weaknesses in the management of the ward.

Supervision records lacked details about support in clinical development. The system for storing supervision records was not effective, although the ward manager had requested a new lock for the filing cabinet.

- The provider introduced ward manager reports in November 2016 to provide ward managers with important information about the running of the ward. For example, supervision and appraisal rates, audit outcomes and incident reporting.
- The hospital had a risk register showing how the hospital would respond if situations arose that could harm staff or patients, or prevent services from being provided. However, none of the staff on the ward were aware of this. Staff did have the opportunity to raise concerns for inclusion on the risk register.
- During the inspection, the hospital was going through a substantial development. Building work was taking place to refurbish the existing wards and create a new ward, due to open by the end of 2017.

Leadership, morale and staff engagement

- The ward manager provided leadership to staff on the ward. This manager was new to the role having started in their post two weeks before the inspection. However, in this short time they had identified areas for improvement, such as regular reflective practice sessions and embedding the process for recording one-to-one sessions. Staff and patients were very positive about the new ward manager.
- The sickness rate in the 12 months before the inspection was low at 1%.
- Staff did not make us aware of any bullying or harassment taking place.
- Staff were aware of the whistleblowing process and said they would feel confident in doing this if they felt it necessary. Staff said that they would feel confident to raise a concern without the fear of victimisation.
- Staff said that morale was good and that they felt supported in their roles. Staff said the team were supportive of one another.
- Some staff we spoke with said they were aware of the learning opportunities available to them. They said the provider was responsive if approached about developmental and learning opportunities.

Commitment to quality improvement and innovation

Long stay/rehabilitation mental health wards for working age adults

Good 

- The hospital recently introduced the role of expert by experience. The role of this person, who is a patient who

has been discharged from using similar services, is to work alongside the hospital manager to identify areas for improvement. It was planned that they would be involved closely with service development.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that separate areas of Byron ward are designated for male and female patients.
- The provider must ensure that staff carry out alcohol detoxification safely. Patients admitted Byron ward for detox were not assessed prior to commencing their treatment using recognised tools. Some patients did not have some physical health tests completed prior to commencing their treatment. Nursing staff and nursing assistants had not received specialist training in relation to alcohol detoxification.
- The provider must ensure that staff on the Springs unit support patients to enable them to maintain appropriate standards of cleanliness and tidiness.
- The provider must ensure there are sufficient safeguards to prevent the risk of excessive restriction and de facto detention when carrying out one-to-one observations of informal patients on Byron ward.
- The provider must ensure that governance systems to ensure the safety and quality of the service are robust. On Byron ward there was also no system in place to ensure that concerns and issues raised by staff were listened to and acted upon.
- The provider must ensure that staff on the Springs Unit discuss serious incidents and share learning from incidents.

Action the provider **SHOULD** take to improve

- The service should ensure that, on all three wards, staff supervision is provided consistently in accordance with the organisations policy. Supervision on all three wards did not always address clinical practice. Supervision records were not always available. On the Springs wing, supervision records should be stored appropriately.
- The provider should ensure compliance with all mandatory training courses.
- The provider should ensure that ward staff are fully involved in a comprehensive programme of audits.
- Staff should ensure all expired medical items are removed from Springs Wing in a timely way
- The provider should ensure that care plans for patients detained under sections 3 and 37 of the MHA include details of the patient's right to aftercare. The provider should ensure the system to record leave is effective and captures all required information.
- The provider should ensure that physical healthcare interventions on the Spring Wing are carried out consistently in accordance with patients' care plans.

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 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA (RA) Regulations 2014 Person centred care. Constant observations of informal patients took place without sufficient safeguards to prevent the risk of excessive restriction and de facto detention. This was a breach of regulation 9(1)
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 HSCA (RA) Regulations 2014 Person centred care. The provider did not provide designated areas for male and female patient's bedrooms. Staff propped open doors during observation. This could compromise patients' privacy. This was a breach of regulation 10(2)(a)
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 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

The risks of alcohol detoxification on Byron ward were not being sufficiently mitigated.

This was a breach of regulation 12(1)(2)(b)(e)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

On the Springs unit, some patients' bedrooms were not clean. Staff did not effectively support patients keep bedrooms safe, clean and tidy. The provider must maintain standards of hygiene.

This was a breach of regulation 15(1)(a)(2)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Byron ward and Springs Unit did not have systems to record or act on feedback from staff and patients.

On the Springs Unit, staff did not discuss serious incidents at a ward level.

There were insufficient systems or processes to assess, monitor and improve the health, safety and well-being of patients.

This was a breach of regulation 17(1)(2)(b)(d)(e)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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