

Requires improvement 

# Nottinghamshire Healthcare NHS Foundation Trust

## High secure hospitals

### Quality Report

Rampton Hospital  
Retford  
DN22 0PD  
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### Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RHA04	Rampton Hospital	<b>Aintree</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Cheltenham</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Kempton</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Newmarket</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Adwick</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Alford</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Blake</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Bonnard</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Burne</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Cambridge</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Canterbury</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Erskine</b>	DN22 0PD
RHA04	Rampton Hospital	<b>Grampian</b>	DN22 0PD

# Summary of findings

RHA04	Rampton Hospital	<b>Brecon</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Cheviot</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Cotswold</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Eden</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Evans</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Hambleton</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Malvern</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Quantock</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Emerald</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Jade</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Ruby</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Topaz</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Creswell Day Unit</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Diamond Resource Centre</b>	DN22 OPD
RHA04	Rampton Hospital	<b>Southwell Centre</b>	DN22 OPD

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Nottinghamshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare NHS Foundation Trust.

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

### Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Good



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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

Our rating of this service stayed the same. We rated Rampton Hospital as requires improvement because:

- We rated safe and responsive as requires improvement and effective, caring and well-led as good.
- Although the trust has a recruitment and retention strategy, there remained a high level of staff vacancies and turnover. The hospital had undertaken a strategic staffing review and used a recognised tool to determine the establishment of staff required on each ward. Despite this, there were often too few staff on the wards. As a result, staff could not always supervise patient activities, support patients to attend health appointments or carry out observations without cancelling other tasks, closing part of a ward or moving staff from one ward to another to maintain safety.
- Although the number of instances had reduced, there were still occasions when there was only one member of staff (nurse) on a ward at night.
- Staff did not keep complete and accurate records of tasks relating to patient safety. They did not always record reviews of patients in seclusion and long term segregation in accordance with the Mental Health Act Code of Practice.
- Although, since the last inspection, staff had improved the way they carried out and recorded observations, we still found some errors in recording during this inspection.
- Although the consistency of clinical record keeping across the hospital had improved since the last inspection, some patient care plans were still not of the high standard that would be expected of such a specialised hospital.
- There was a problem with the system on which staff recorded the number and hours of activities that patients engaged in that meant that the provider did not have a true and accurate record of these.
- Not all staff had a good understanding and knowledge of physical healthcare conditions in order to implement care plans effectively. This included the care of patients with, or at risk of developing, diabetes.
- There were signatures missing from some medication charts and because of the movement of staff across wards, it was not always clear which nurse was responsible for administering the medication.
- Some staff wore nail varnish and gel nails. This was not in line with trust policy and was also raised as a concern during the last inspection.

# Summary of findings

## The five questions we ask about the service and what we found

### Are services safe?

Our rating of safe stayed the same. We rated safe as requires improvement because:

- There were high staff turnover, sickness and vacancy rates and there were still occasions when there was only one nurse on duty on a ward at night. At January 2018, 12% of posts for nurses were vacant (53 whole time equivalent posts).
- Staff did not review seclusion and long term segregation in line with the requirements set out in the Mental Health Act Code of Practice.
- We saw errors in the way observations were being recorded on some wards.
- We saw missing signatures on medication charts and staff were not aware which nurse was responsible for administering medication.
- Some staff did not comply with the trust infection prevention control policy as they wore nail varnish and gel nails.

However:

- The hospital had over-recruited nursing assistants. In January 2018, the number was 19% higher than the establishment figure.
- The environment was safe and secure and all wards had completed up to date environmental risk assessments.
- Each ward had an emergency bag and records showed the major incident trolley had been checked regularly.
- Mandatory training rates were good and staff demonstrated a good understanding of safeguarding children and adults.
- Clinic rooms were secure, clean and tidy.
- There was evidence lessons were learned following incidents.
- The Ministry of Justice security audit found the hospital to be good.

Requires improvement



### Are services effective?

Our rating of effective improved. We rated effective as good because:

- There was evidence of physical health monitoring and all patients had received a physical health assessment upon admission.
- There was low use of rapid tranquilisation and of high dose anti psychotics and we saw evidence that doctors followed national guidelines when prescribing.

Good



# Summary of findings

- The hospital offered a range of evidence based therapies and used rating scales to monitor the frequency and severity of symptoms.
- A high proportion of staff received regular supervision and an annual appraisal of their work performance.
- Each ward held regular multidisciplinary meetings and we saw evidence of good joint working across the hospital and with external stakeholders.
- A high proportion of staff had received training in the Mental Health Act and Mental Capacity Act.

However:

- The quality of care plans across the hospital was variable and it was not always clearly recorded whether the patient had been offered a copy of their care plan or not.
- Care plans in the learning disability service were not completed in the patient's voice and there were no positive behaviour support plans.
- Patients diagnosed with diabetes did not always have care plans in place. Three patients with diagnosed diabetes, and one where the patient had been identified as being at risk of developing diabetes, did not have care plans in place or records to show that blood sugar monitoring was completed.
- Not all records showed a Mental Capacity assessment had been completed on a decision specific basis.
- Staff on different wards stored important information in different places. This meant that staff moving between wards may not know where to record or find vital information about the patients' care.

## Are services caring?

Our rating of caring stayed the same. We rated caring as good because:

- We observed staff interacting positively with patients. They showed warmth and understanding of their patients' needs and used de-escalation techniques effectively.
- Patients said the majority of staff went the extra mile and the ward staff worked really hard to make sure everyone felt safe.
- We observed patient-led community meetings where patients were able to raise concerns and receive feedback.

However:

- Patients said there were often unfamiliar staff on their wards due to the high level of staff movement across the hospital.

Good



# Summary of findings

- Some patients commented they felt staff did not listen to their views.

## Are services responsive to people's needs?

Our rating of responsive stayed the same. We rated responsive as requires improvement because:

- There were high bed occupancy rates which meant there were waiting lists for some services.
- Staff and patients reported that activities on and off the ward were cancelled due to staffing issues. Insufficient staffing also impacted on the frequency of patients' access to fresh air and ground leave.
- The system used to record activities did not always get changed to accurately reflect what activities patients had completed.
- The shop within the secure perimeter that patients accessed had limited stock and prices were high.
- Patients with hearing impairments were unable to access church or the Rainbow club (a club to support the lesbian, gay, bisexual community) due to there being insufficient interpreters.

However:

- There was a good range of rooms and equipment to support treatment.
- There were safe visiting facilities for children.
- Records showed staff knew how to handle complaints and learning was shared and feedback given.

Requires improvement



## Are services well-led?

Our rating for well-led improved. We rated well-led as good because:

- Since the last inspection, the leadership team had made significant progress. We saw an increase in staff engagement and morale had improved. Staff spoke more positively about the senior leadership team and their relationship with them, as well as the things they had introduced including the nursing council. Staff felt more able to raise concerns and approach managers than they did during the last inspection.
- Communication between the wards and the board was good. Staff and patients could raise concerns; contribute to service development and delivery.
- Mandatory training levels, including safeguarding were above the trust target and staff received supervision and appraisals.
- The hospital worked closely with the two other high secure hospitals across England; Broadmoor and Ashworth.

Good



# Summary of findings

However:

- There were still areas that required significant improvement; despite the hospital introducing several strategies to improve staffing, we found there remained insufficient staff. Staff were still regularly moved between wards, activities were cancelled, ward areas were closed and patients were able to go outside less often. This affected patients' care and wellbeing.

# Summary of findings

## Information about the service

Rampton Hospital, which is managed by Nottinghamshire Healthcare NHS Foundation Trust, is one of three high secure hospitals in England. NHS England is responsible for commissioning all high secure hospitals. Patients are only admitted to Rampton Hospital if they are referred by a health professional and assessed by the hospital as meeting the criteria for admission. All patients admitted to the hospital are detained under the Mental Health Act 1983.

The hospital follows the High Secure Hospital Directions (2013) and Guidance from the Secretary of State for Health. The providers must comply with certain aspects of the Directions and have discretion about others aspects such as night time confinement.

Rampton Hospital provides the following services ;-

### **National Women's Service with 50 beds;**

- Emerald (learning disability and intensive care).
- Jade (mental illness).
- Ruby (personality disorder).
- Topaz (personality disorder admission ward).

### **National learning Disability Service with 52 beds for men;**

- Aintree (positive behaviour therapy ward).
- Cheltenham (assessment and admission ward).
- Kempton (physical healthcare/positive behaviour therapy ward).
- Newmarket (therapeutic community).

### **National deaf Service with 10 beds for men;**

- Grampian ward.

### **Mental Health Service with 134 beds for men;**

- Adwick (intensive care).
- Alford (continuing care and treatment).
- Blake (admission and treatment).
- Bonnard (admission and treatment).
- Burne (admission and treatment).
- Cambridge (pre discharge and physical healthcare).
- Canterbury (rehabilitation and pre discharge).

- Erskine ward (admission and treatment).

### **Regional Personality Disorder service including the Peaks unit for people with enduring and severe Personality Disorders with 94 beds for men;**

- Eden (PD treatment).
- Evans (PD treatment).
- Brecon (high dependency).
- Cheviot (admission and assessment).
- Cotswold (treatment).
- Hambleton (treatment).
- Malvern (treatment).
- Quantock (treatment).

Since the last inspection, Rampton Hospital has implemented the 'One Hospital' model. This means there are now four care pathways, all operating in a more consistent manner these are; mental health, personality disorder, learning disability and women's. The management and leadership structures at the top of each care pathway report into one operational manager who has oversight of all the ward staff. The therapies and education staff are aiming to align themselves with one care stream in order to be able to attend multi-disciplinary meetings and deliver more effective care. Each care pathway will have dedicated responsible clinicians and medical staff.

From April 2017, the number of beds at Rampton Hospital reduced from 357 to 340 and the Peaks Unit (for men with enduring and severe Personality Disorders) and the Personality Disorder Service merged to form the personality disorder pathway.

In December 2017, there was a change of bed numbers in the following areas;

Male learning disability service, reduced from 54 to 52, male mental health beds increased from 128 to 134 and the male personality disorder beds reduced from 98 to 94.

At the time of inspection there were 302 patients, over 26 wards.

# Summary of findings

## Our inspection team

The team that inspected this core service consisted of; two CQC inspection managers; four Mental Health Act Reviewers; 12 CQC inspectors; one CQC assistant inspector; the CQC National Professional Advisor for forensic mental health services; 19 specialist advisors including, psychiatrists, mental health nurses,

occupational therapists, psychologists and advisors with specific knowledge around safeguarding and information governance; two CQC analysts; and three experts by experience (an expert by experience is someone who has personal knowledge of using or supporting someone using a mental health service).

## Why we carried out this inspection

We undertook this inspection of Rampton Hospital to check whether the provider had made the improvements required following our previous inspections of the hospital. CQC also wished to form a view about the current quality and safety of care provided at the hospital so that it could provide advice to the Department of Health and Social Care as part of the authorisation process for the three high secure hospitals. We plan our inspections based on everything we know about the service, including whether they appear to be getting better or worse.

### Previous inspections and monitoring

CQC undertook a comprehensive inspection of Nottinghamshire Healthcare NHS Foundation Trust in May 2014. The forensic service, of which Rampton Hospital was part, was rated as good overall and as good in all domains; safe, effective, caring, responsive and well led.

CQC undertook a focused inspection of four wards at Rampton Hospital in March and April 2016 following concerns about staff not carrying out observations of patients correctly. Following that inspection, we issued a warning notice focused on this issue.

CQC carried out a follow up inspection in August 2016 and found that the hospital had made improvements.

CQC completed a comprehensive inspection of Rampton Hospital in March 2017. Following that inspection, we rated the hospital as requires improvement for safe, effective and responsive, good for caring and inadequate for well led. The report that followed this inspection stated the provider must make the following improvements;

- The provider must ensure that sufficient staff are deployed across the hospital at night to avoid lone working.
- The provider must ensure that there are sufficient staff deployed across the hospital during the day so that activities are not cancelled due to staffing needs.
- The provider must ensure that all staff adhere to the infection, prevention and control policy and dress code policy.
- The provider must ensure that all National Early Warning Scores are calculated and entered into the electronic records system.
- The provider must ensure that all fire doors are kept shut at all times in line with fire regulations.
- The provider must ensure that the major incident trolley is checked regularly.
- The provider must ensure that all staff are aware of lessons learned from incidents and complaints.
- The provider must ensure adherence to the Mental Health Act Code of Practice regarding seclusion and long-term segregation practices.
- The provider must ensure adherence to the Mental Health Act and the Code of Practice regarding Section 134 mail monitoring.
- The provider must review whether the staffing situation is contributing to staff using more restrictive interventions than would otherwise be required.

We have monitored the provider since the last inspection and found the provider has made progress towards

# Summary of findings

meeting the majority of the above requirements. There remained actions outstanding that related to staffing and lone working, but the trust was making progress towards these.

We carried out four Mental Health Act review visits in March 2018, to the following wards at Rampton Hospital:- Topaz, Emerald, Cheltenham and Ruby.

In November 2017, CQC undertook an inspection of four core services provided by Nottinghamshire Healthcare NHS Foundation Trust. This inspection did not include Rampton Hospital. Following that inspection, CQC rated the Trust as good overall (good in effective, responsive, caring and well-led domains and requires improvement for safe).

## How we carried out this inspection

We inspect and regulate healthcare service providers in England. To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs and well led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against registered service providers and registered managers who fail to comply with legal requirements, and help them to improve their services.

The inspection was announced to ensure that everyone we needed to speak to was available.

Before the inspection visit, we reviewed information we held about the service and requested information from the trust.

During the inspection visit, the inspection team:

- Visited all wards and looked at the quality of the ward environments and observed how staff cared for patients.

- Spoke with 126 individual staff members, including ward managers, deputy matrons and matrons, members of the security team and senior leadership team, nurses, nursing assistants, psychologists, psychiatrists, social workers and occupational therapists.
- Held 12 focus groups for all groups of staff.
- Spoke with 75 patients.
- Looked at 79 care and treatment records of patients.
- Reviewed medication management, including 106 medication administration charts for patients'.
- Attended and observed five multidisciplinary meetings and eight community meetings. We also observed a football discussion group, advocacy session on Grampian ward and saw the hospital band.
- Looked at a range of policies and procedures and other documents relating to the running of the hospital.

## What people who use the provider's services say

- We spoke with 75 patients and received 61 comment cards. The majority of the comments were positive and described the staff as kind, caring and supportive.
- Patients told us they did not like it when unfamiliar staff were moved onto their wards and activities cancelled. It made them upset and frustrated.
- They reported the environment was mostly clean and comfortable and had everything they required to support their treatment and recovery.
- They said the food was of a good quality and there were healthy options to choose from.
- The patients spoke positively about the range of things they get involved in with staff, particularly the events to raise money for charity.

# Summary of findings

- We heard from one carer who thought the hospital shop was extremely expensive and had a poor range

of products. The carer's champion had been unavailable by email when they wanted to contact them and they were concerned their family circumstance report was not updated.

## Good practice

We found the following outstanding practice:

- The extended role of the advanced nurse practitioner in surgical removal of foreign bodies which meant the patient did not have to leave Rampton Hospital to attend a local emergency department.
- Rampton Hospital had continued to train staff in the harnessing opportunities, protective enhancement system (HOPE(s) model). This was a framework developed by another high secure hospital that supported the multidisciplinary team help patients move beyond long term segregation.

- Achieving the Sense of Community CQUIN (Commissioning for Quality and Innovation) for 2017. A CQUIN is a target set by NHS England to try and improve quality. The sense of community projects aimed to enhance the sense of community and develop a positive community atmosphere. All eight wards involved produced something that was meaningful to them as a ward including; a model ship, football mural, a ward band and garden that produced vegetables and flowers.

## Areas for improvement

### Action the provider MUST take to improve

Action the trust MUST take is necessary to comply with its legal obligations.

### Action the trust MUST take to improve

We told the trust that it must take action to bring the service into line with legal requirements.

- The provider must ensure there is adequate staffing across the hospital in order to facilitate on and off ward activities, ground leave, access to fresh air and reduce the frequent movement of staff during shifts to other wards.
- The provider must continue to monitor incidences of lone working at night and take steps to eliminate it.
- The provider must ensure there is a system that records the amount of activities that patients engage in are accurate and this is used by staff.
- The provider must ensure staff feel confident and are competent to implement physical healthcare plans effectively.

- The provider must ensure staff adhere to the trust's infection control policy.
- The provider must ensure that all staff adheres to the trust wide observation policy when recording observations.
- The provider must ensure recording of seclusion and long term segregation reviews are undertaken in accordance with the Mental Health Act Code of Practice.
- The provider must ensure that nurses are aware of who is responsible for administering medication each shift and that all medication is signed for.
- The care plans in the learning disability service must be completed in the patients' voice.

### Action the provider SHOULD take to improve

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action.

We told the trust that it should take action either to comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in future or to improve services.

# Summary of findings

- The provider should ensure that all staff have undertaken physical healthcare training and has a good understanding of sepsis.
- The provider should ensure that they continue to improve consistency regards to record keeping and where information is stored.
- The provider should consider undertaking a review of the price of goods sold in the patients shop.
- The provider should continue to take actions to improve medical engagement in management decision making.

# Nottinghamshire Healthcare NHS Foundation Trust

## High secure hospitals

### Detailed findings

#### Locations inspected

**Name of service (e.g. ward/unit/team)**

All wards visited

**Name of CQC registered location**

Rampton Hospital

#### Mental Health Act responsibilities

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

We found most staff across the hospital had a good understanding of the Mental Health Act and their duties in respect of the Code of Practice and they were up to date with training. At the time of inspection all ward based services had a compliance rate of above the trust target of 80%. The therapies and education department, compliance rate was 78%.

We found the majority of reviews of seclusion and long term segregation reviews were not completed in accordance with the Mental Health Act Code of Practice as they had not been reviewed within the correct time frame.

Records showed staff were not always informing patients of a decision to withhold an item of mail within 7 days under section 134. This was a concern during the last inspection.

Records showed patients' rights were provided with an explanation of their rights at appropriate intervals and in line with section 132 of the Mental Health Act.

Consent to treatment cards were correctly stored with their medication cards.

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

All staff had a good understanding of the Mental Capacity Act and were up to date with their training. Staff were able to demonstrate how they supported patients in making decisions about their care. However, records showed variability in the detail of the mental capacity assessments.

We saw three records out of seventy nine records we looked at showed the patient had made an advanced decision.

All patients at Rampton Hospital are detained under the Mental Health Act so Deprivation of Liberty Safeguards are not applicable.

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

\* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

## Our findings

### Safe and clean environment

- The hospital had a site and security liaison team who were responsible for maintaining the safety and security of the site. The security level was equivalent to a Category B prison to prevent escape from within the secure perimeter. There have been no incidents of patients escaping outside of the secure perimeter.
- Physical security was only breached when relational and procedural security had already been breached. This means the safety of the wards relied on staff relationships with the patients and their adherence to the hospitals policies and procedures. We did not see any breach of physical security during the inspection.
- Rampton Hospital consisted of a number of buildings which ranged in age. This meant the condition of the facilities varied depending on which building the ward was in. There was a refurbishment plan in progress to ensure the estate was kept safe and secure and fit for purpose. Since the last inspection, there had been some outside walls knocked down in order to increase the space for patients ground leave.
- The ward areas were clean, except for a few areas. The seclusion room and de-escalation room on Ruby ward was notably dirty and untidy. One of the two seclusion rooms on Aintree ward, which was out of service due to a broken hatch, had a strong odour of urine and faecal matter on the door frame to the ensuite. Both seclusion rooms on this ward had a blind spot directly underneath the ensuite shower area, but staff were aware of this and knew how to mitigate the risk.
- The furnishings were well maintained throughout in ward areas, but in some office areas, in the older parts of the building, we saw chairs with ripped covers and tired looking office furniture. In some services, we saw there was new specialist furniture. For example; a large, chair/beanbag with arms that wrapped around a person. This helped distressed patients feel safe and secure and more grounded
- There were housekeepers on the majority of the wards and we saw evidence that demonstrated regular cleaning took place. Some of the patients were able to clean their own rooms if they wished.
- The 2017 patient led assessments of the ward environment were 98.4% for cleanliness and 97.2% for the condition, appearance and maintenance of the hospital. Both of these scores had improved since the last inspection and were above the national averages.
- All wards were compliant with guidance on same sex accommodation.
- Ward managers had completed environmental risk assessments including, ligature risk assessments which were up to date and reviewed regularly. Any ligature point risks were managed through staff observation and CCTV. When staffing levels fell we saw staff had to close off areas of the wards in order to maintain safe observations. This further restricted the patients' movements and limited their choices about where to spend time. There were five incidents showing occasions when staff closed off areas of the ward due to staffing issues between January and March 2018.
- Patient bedroom and bathroom doors were designed to prevent self-harm through holding, barring or blocking. Doors and windows in rooms had observation panels with either integrated blinds or curtains on the outside of the rooms. Patients could choose whether to keep these open or closed but staff could override their decision based on individual risk assessment.
- There was a dedicated infection prevention and control (IPC) team available on site. This team conducted monthly ward audits and provided advice to ward staff.
- We asked to see the IPC audit of the physical health care centre but were advised one hadn't been completed. This area was a clinical one where significant invasive treatments such as minor surgery took place, so the risk of the spread of infection was not being robustly monitored. The trust have advised that this will be completed in April 2018.

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

- The physical healthcare centre was suitably equipped with dedicated rooms for dental and optical care. All areas were visibly clean. Equipment checks were completed and fridge temperatures were monitored and with accepted ranges.
- All medications checked were within date. Anaphylaxis packs were in date and available to treat shock.
- Staff were not complying with the infection prevention control policy. We observed ward staff with nail varnish and gel nails working throughout the hospital. Since the last inspection, the hospital had reached a specific agreement with the Infection Prevention Society regarding what 'Bare below the Elbows' should mean in a mental health setting. This was as follows: Any person working with patients should not wear rings with stones, or gel or false nails; The term clinical procedure, in mental health settings refers to procedures which would typically be performed within a clinic room, for example the administration of medicines and the range of physical health testing; Any person undertaking a direct clinical procedure including administering medication must be 'Bare below the Elbows'. 'Bare below the Elbows' is defined as: hands and arms to the elbows/ mid forearm are exposed and free from clothing/ jewellery. This means, sleeves should be rolled up or short, no wrist watches or hand or wrist jewellery apart from a plain wedding band and ties and lanyard badges tucked in or removed.
- We observed the physical healthcare team mostly adhering to good infection prevention control practices. We did however observe one dressing being completed with a sterile pack but non-sterile gloves were used.
- Training rates for nursing and medical staff on Infection Prevention Control and hand hygiene were 82%. Since aseptic wound care training commenced in June 2017, 39 staff have received this training and further training was planned.
- We observed staff using hand sanitiser and these were available at the entrance to every ward.
- All of the staff carried an alarm and there were nurse call systems in each bedroom.
- All of the electrical equipment we looked at had been tested and was in date.
- Since the last inspection the trust have undertaken a strategic staffing review of the hospital and used a nationally recognised benchmarking tool to support the review and to calculate the establishment required. The hospital had also revised and relaunched its recruitment and retention strategy. This included; an introduction of an allowance for nursing staff; improved student nursing and nursing accommodation; established a nursing council, increased engagement with universities and ensured a presence at national recruitment events. Furthermore, the executive director of forensic services met with every staff leaver in order to understand the reasons for leaving and the associate director of nursing for forensic services also meets with staff who were at risk of leaving.
- The outcome of the review included an increase to the night time establishment to three staff per ward (starting April 2018) and an increase to the daytime establishment on the following wards; Emerald, Topaz, Ruby, Adwick, Brecon, Aintree, Cheltenham and Kempton. The total difference per shift was an increase of 12 staff. The day time increase has been in place since August 2017.
- Since the last inspection there had been an increase of establishment to 365.49 nurses, 433.76 nursing assistants and 9.79 night pool staff.
- The hospital has its own bank of staff and did not use agency staff.
- The physical healthcare team was fully staffed with no vacancies. No bank or agency staff were used. Absence due to sickness or leave was covered by other staff or the provision of services were planned if advance notice of leave was known.
- The vacancy rate for qualified nurses in January 2018 was 12.3 %, which meant there were 53 actual whole time equivalent vacancies. The sickness rate as of February 2018 was 6.9%. The average turnover rate between July 2017 and February 2018 was 8%. The over recruitment of nursing assistants meant the vacancy rate was -18.6% in January 2018.
- The hospital, under direction 35 of the High Security Psychiatric Service Directions, 2013, operated a policy where the patients were confined to their rooms at night. If there were any risks that required the patient to be excluded from this, the doctor would complete a

## Safe staffing

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

form explaining the reasons and a care plan implemented. At the time of inspection, there were seven patients risk assessed to not be suitable for night time confinement.

- Since the last inspection, the trust have been recording the incidents of lone working at night and submitting them to the board. In January 2018 there were 20 recorded incidents of lone working. This was an improvement since the last inspection.
- Seven nurses told us they were not able to have regular 1:1 time with their patients due to insufficient staffing on the wards. They said they come in on their days off in order to be able to complete named nurse duties. The hospital told us it was trying to implement protected time in their day to complete these duties.
- The ward manager completed the rota for their ward and it was then signed off by the matron. Any day to day changes due to patient acuity or staff sickness were sent to the Central Resource Office. This team had oversight of the needs of the whole hospital and could deploy staff accordingly. The team tried to ensure that staff were moved to wards they were familiar with but this was not always possible. All of the ward staff we spoke with said they did not like moving to unfamiliar wards.
- Staff and patients said that activities were frequently cancelled both on and off the ward due to staffing issues in order to maintain safety. Records showed the hospital offered each patient, 25 hours of activity per week. In February the average number of hours offered was 29. In the six months prior to inspection, there were three main reasons why activities did not go ahead according to the electronic activity recording system. These were; 77% patient choice; 14% patient unwell; 6% staffing reasons.
- However, 22 staff involved in delivering activities told us that the activity recording system was not accurate and did not reflect what actually happened. It was a preloaded timetable and any extra or fewer activities that happened or got cancelled did not always get altered, therefore the figures were not accurate.
- Staff told us they were not always able to have breaks from continuous observation. We saw the hospital had completed an audit during a week in November 2017. This showed that out of 323 staff that were on the rota to undertake more than one hour of continuous observation, 171 completed up to two hours of continuous observation. The rest completed more than two hours and one staff member went 10 hours without a break from observation. National Institute of Clinical Care and Excellence guidance states staff should not complete more than two hours of observation without a break. The hospital had implemented a buddy system to try and resolve the issue and help with planning rotas.
- Staff said they could contact a doctor in an emergency if needed, day or night. However, they said they only saw a doctor at other times on the wards, if there was a meeting.
- There were not always enough staff to carry out physical healthcare checks. For example, there was a serious incident which resulted in a patient fracturing their hip. Staffing issues delayed the patient being physically examined for two days and taken to a local acute hospital for treatment.
- The clinical director told us the consultants' caseloads were up to 25 for all services except women's where they were up to 15. Since the last inspection, the hospital had started to align consultants to specific services in order to make it easier for them to attend multi-disciplinary meetings. However, therapy staff still had patients across the hospital on their caseloads which made it harder for them to attend multi-disciplinary meetings. Their caseloads were also up to 25. They told us they were just about managing to meet the clinical need on their caseloads but due to staffing pressures they struggled to provide reflective time for staff and sometimes had to cut sessions short.
- Staff had received and were up to date with mandatory training. The ward manager had a dashboard they used to monitor compliance rates and remind staff when they were due for training. Some staff were unclear whether medicines management training was mandatory and how often it was required. We raised this lack of clarity with pharmacy and found out that competence checks were required every three years via an eLearning module that included a medicines section which should be completed annually.
- Mandatory training rates across the hospital were mostly above 80%, except for women's service had a

# Are services safe?

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compliance rate of 77% for Care Programme Approach training and the security team had compliance rates of 78% for Clinical Risk training and 77% for Mental Capacity training.

## Assessing and managing risk to patients and staff

- We looked at 79 care records and they all contained a recognised risk assessment tool that was up to date and reviewed regularly and after every incident. The risk assessment tool used covered a wide range of risks including harm to self, risk of aggression and risk to children. The trust said they were reviewing the tool to ensure it continued to be fit for purpose.
- All of the staff we spoke with demonstrated they had a good understanding of least restrictive practice. This means that staff aim to use minimal levels of physical and procedural intervention in order to provide a safe and recovery focused environment. Records showed between December 2017 and February 2018, the average length of time spent in full restraint was 10 minutes, passive restraint was eight minutes and de-escalation was one hour.
- There were 948 incidents of restraint between 1 February 2017 and 28 January 2018. Emerald ward (the learning disability, intensive care ward for women) had the highest incidences of restraint with 276 incidences. This had reduced since the last inspection.
- In the same time frame there were 326 incidents of prone restraint. This means that staff held the patient lying face down. Emerald also had the highest incidence of prone restraint with 112 incidences.
- Rampton Hospital used mechanical restraint, which is any restrictive device that is used to restrict a person's free movement, most commonly used in emergencies to protect the patient from self-harming. The staff who worked in the services where this was used had a good understanding of the devices and their training was up to date. The decision when to use mechanical restraint was made by the ward team, the on call manager and a site and security liaison manager and where possible the on call doctor. This was in line with the trusts policy and the Mental Health Act Code of Practice.
- There had been 297 incidents of mechanical restraint between 1 February 2017 and 28 January 2018 and again, Emerald (the learning disability, intensive care ward for women) had the highest incidents of mechanical restraint with 179 incidences. This had reduced since the last inspection.
- The hospital had used intra muscular rapid tranquilisation 90 times; two thirds of those rapid tranquilisation incidences were on Emerald ward (the learning disability, intensive care ward for women). The hospital explained the acuity of women on Emerald ward had been very high during the 12 months prior to inspection. The use of rapid tranquilisation followed National institute of Health and Care Excellence guidelines. However, on the women's wards, some staff were unable to give a clear description of the physical health checks required after rapid tranquilisation had been administered.
- We reviewed eight seclusion records and 13 long term segregation records. We also spoke to 20 patients and 18 staff, specifically about seclusion and long term segregation.
- Between 1 February 2017 and 28 January 2018, there had been 785 incidents of seclusion and 584 incidents of patients in long term segregation. We saw long term segregation had reduced overall but there had been an increase in seclusion regarding the number of patients and episodes with the duration decreasing.
- The majority of reviews for seclusion and long term segregation were not completed in line with the Mental Health Act Code of Practice as they had not been reviewed in the correct time frame. Five seclusion records showed missing reviews; Hambleton ward record showed the patient had been in seclusion since 11 January 2018 and there had only been one medical review at the start of seclusion. Emerald A record showed there had not been any multi-disciplinary team review for 30 hours after the start of seclusion. It should have been every four hours. Adwick ward record showed there had been only two medical reviews in a 43 hour period. On Erskine ward, the record showed there had only been one medical review within four days. Aintree ward showed there had been no medical review for 72 hours. Seven long term segregation records showed during February and March 2018, daily reviews had not taken place on several occasions; Erskine record showed a daily review had not taken place on 21 out of 28 days. Aintree record showed there had not been a

# Are services safe?

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daily review 15 out of 30 days. Adwick ward record showed not been reviewed for 11 days. Kempton ward record showed there had not been a review for 15 days and two records on Emerald A ward showed there had not been any daily reviews taking place. Staff were unable to tell us why this had been the case. Ward staff were observing and recording the patients in seclusion and long term segregation every fifteen minutes.

- The three high secure hospitals worked together to provide external reviews for long term segregation. The most recent review concluded that the hospital was managing the long term segregation appropriately.
- We did not note any unnecessary blanket restrictions given the requirements of the High Security Psychiatric Services Directions 2013; these were mostly around contraband items. Each ward risk assessed individual patients with regard to what was safe for them to access. We saw some patients had CDs in their rooms and on some wards there was open access to the kitchen so patients could make themselves hot drinks and snacks.
- All of the staff were able to explain the observation policy but we saw some records in the women's service where the observation sheets were not being completed in line with the policy. For example; records showed, staff completed general observations and signed at exactly the same time on the half hour for every patient. The trust have invested in the development of an app that staff can access via specific hand held devices in order to complete clinical observations. This app will ensure accurate timings and presentation of the patient at the time of the observation will be recorded and reported on. This initiative is due to be rolled out in Rampton Hospital in September 2018.
- The staff we spoke with had a good understanding of the search policy and the records of searches we looked at reflected this.
- All of the staff we spoke with had a good understanding of safeguarding and were trained in safeguarding adults and children. There was a family centre where children visited and we saw robust procedures in place that would ensure the children's safety while visiting. The training rates for safeguarding children and adults were all above 88% in all services. The mental health service had a compliance rate of 100%.
- There was good medicines management in place across the hospital. We spoke to the pharmacy team, visited all of the clinic rooms and looked at 106 medicine charts.
- The clinic rooms we looked at were tidy and clean and records showed fridge and room temperatures were generally monitored appropriately. Where there had been gaps in the past pharmacy team had raised this with the ward staff.
- Medicines including controlled drugs were stored securely throughout the hospital with appropriately controlled access. The medicine charts were mostly complete including allergy information and staff had noted when patients refused medication. However, on Ruby ward there were three charts, over a period of three months, where seven medicines had no signatures recorded against their administration times. This included two occasions that related to Clozapine. It was not clear whether the patients had been given their medication and the staff member had failed to sign the chart or whether the medication had been missed. We raised it with the nurse on the ward at the time and they explained that this had likely happened due to the increasing numbers of staff moving on and off the ward and difficulty in keeping track of who was responsible for administering the medication. These gaps in administration had been identified by the pharmacy team and incident forms completed.
- Improvements had occurred in pharmacy stocktaking of medicines and charts leaving the ward since our last inspection. There was now a regular service from the pharmacy team to the wards, which minimised the need for medicine charts to leave the wards.
- Staff were aware of and addressed any issues regarding falls and pressure ulcers. Records showed in January 2018, a serious incident was reported regarding the presence of a pressure ulcer in the women's service. The trust investigated and found improvements could be made to the assessment and monitoring process.
- The trust used a National Early Warning Score assessment tool (NEWS); this uses a range of physiological observations to indicate if a patient may be physically deteriorating.
- We looked at the NEWS records for 26 patients. All apart from one was completed and totalled correctly. Where

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there were elevated scores nursing staff had alerted medical staff appropriately. However, we did not see any records where patients were screened for sepsis in line with trust policy if scores were elevated.

- Intravenous antibiotics were not available onsite and if sepsis was suspected transfer to the acute hospital was arranged as a medical emergency. Staff told us that on occasions intramuscular antibiotics could be commenced.
- Where patients had developed grade 3 or 4 pressure areas this was recorded as an incident and root cause analysis investigations were completed. There had been one pressure area reported in the 12 months prior to inspection.
- A risk rated register was kept by the physical healthcare team to identify which patients had complex health needs. This was discussed each morning and work allocated to staff. A weekly update meeting was also held to discuss these patients with ward staff. Some wards attended these meetings regularly but others did not.
- In the physical healthcare centre we saw oxygen cylinders were stored in a room without appropriate signage. We alerted staff to this and the cylinders were removed.
- Two electronic patients systems were used in the hospital. Ward staff could not access one of the systems used by the physical healthcare team. Information was cut and pasted from this system into the one used by ward staff. This increased the risk of error or omissions.
- Staff in the physical healthcare team were not clear about their role should a major incident occur and no drills had taken place. An emergency trolley of dressings was stored near the physical health centre. Records were signed to show to verify staff had checked this. Staff we spoke to were not clear in what circumstances the trolley would be used.
- New resuscitation bags had been introduced since our last inspection. These were located on each ward. Records indicated staff had signed that these were checked daily. When used these were replenished by the health centre staff, we saw a used bag was quickly replaced during our visit.

- For medical emergencies that occurred during the physical healthcare team's accessible hours a member of the team always attended. Out of hours the duty doctor attended.
- We observed a medical emergency that took place in an outdoor area. Staff quickly attended to the patient and obtained the emergency equipment they needed. The patient was cared for and kept warm. When sufficiently recovered they were however transported to the ward in a wheel chair without footplates fitted. This posed a risk to the patient of their feet being dragged or caught under the chair.
- An established system was in place to allow ambulances and emergency vehicles access to the wards when this was required.
- The Ministry of Justice carried out a security audit in October 2017. The result was good with a couple of areas of non-compliance around the performance outcomes of managing patient telephone calls. The hospital had put an action plan in place to address and monitor the improvements required.

## Track record on safety

- There had 35 been serious incidents in this service between 1 July 2017 and 9 February 2018. The majority of the incidents had been recorded by the trust as violent behaviour.
- There has been one death in this hospital since the last inspection. The investigation found revealed no concerns about the care provided.
- There was a recent security breach on Adwick ward and measures have since been put in place to prevent the incident from happening again.

## Reporting incidents and learning from when things go wrong

- All of the staff we spoke with knew what an incident was and how to report it on the electronic system.
- Records showed staff were open and transparent and explained to patients when things went wrong, for example, when medication errors happened.
- Staff said they received feedback from investigations via email or from their ward manager. Ward managers told us they received information around lessons learnt via

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email and from the Clinical Incident Review Learning Group. Following a safeguarding incident between patients, there was a review of the social work role in multi-disciplinary meetings in regard to safeguarding practice and this was shared across the hospital.

- Records showed staff and patients were offered debrief following incidents. The hospital was in the process of introducing a new debriefing framework. This included, training specific staff in diffusion training who would check the person's wellbeing and offer various interventions, dependent on need, for example, sign posting to other services, offering time out and

sometimes writing to people at home. We were told staff needed convincing it will be supportive and meaningful and not seen as them being weak. On the staff alarms there was a diffusion button that could be pressed following an incident in order to request debrief. Trained staff will attend the ward in order to complete debrief session.

- Lessons learnt regarding information governance incidents were shared through the divisional lessons learnt leaflet. We have seen evidence to show actions have been taken to mitigate against these risks in the future.

# Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Our findings

### Assessment of needs and planning of care

- We looked at 79 care and treatment records across the hospital and all of them contained a comprehensive assessment upon admission.
- Records showed variability across the hospital as to how person centred the care planning was, but all of the records we saw were up to date. In the women's service, the care plans had mostly improved since the last inspection and were more personalised, three out of fourteen care plans lacked detail.
- In the mental health service the care plans were more recovery focused than during the last inspection and we saw one very good example of a care plan for a patient with autism.
- The personality disorder service had some good examples of recovery orientated care planning.
- The care plans in the learning disability service were completed but not in the patients' voice. We also found this at our last inspection. Staff told us they felt the electronic standardised care plans were difficult to adapt to patients with learning disabilities. We did not see any positive behaviour support plans. We were told the HART (Health and Recovery Tool) documents were positive behaviour support plans. These contained information relating to the patients religion and relationships, as well as their preferences regarding interests and activity choices. It also had sections to support behaviour plans; what am I like when I am well? What keeps me well? However, there was not enough information in them relating to the patients current problems, behaviours and needs and early warning signs. They were also lacking information regarding what treatment and interventions were supporting the patient. This meant that there was an absence of comprehensive positive behaviour support plans as per the Department of Health's guidance regarding positive and proactive care. We were told the hospital is launching an updated version of the HART document that will contain more information regarding positive behavioural support.
- Across all of the services it was not always clearly recorded whether the patient had been offered a copy of their care plan or not.
- The records we looked at showed a physical health examination had been undertaken and there was ongoing monitoring of physical health problems. The quality of the monitoring of physical health problems was variable across the hospital and it was difficult to find care plans on some wards for some long term conditions such as, stoma care. We raised this with the trust and they immediately submitted the care plans to us.
- Patients diagnosed with diabetes did not always have care plans in place. We looked at the records of three patients with diagnosed diabetes and one where the patient had been identified as being at risk of developing diabetes. None of these patients had care plans in place or records to show that blood sugar monitoring was completed. This did not ensure that the patients' health was being monitored effectively.
- Information was stored electronically and also in paper files. The last inspection found staff did not consistently record information in the same place in each ward. The hospital had worked towards resolving this issue and a more consistent approach to where information was being stored was still being embedded. Staff were able to direct us to where information could be found but it remained inconsistent across wards

### Best practice in treatment and care

- We looked at 106 prescription charts and found there continued to be a low use of rapid tranquilisation and limited use of high dose anti psychotics. Doctors followed National Institute of Health and Care Excellence when prescribing medication. Some of the staff when questioned lacked clarity about what they should monitor following the use of rapid tranquilisation. However, records showed physical health monitoring took place.
- The hospital offered a range of therapies recommended by the National Institute of Health and Care Excellence guidance. These included; eye movement desensitisation and reprocessing therapy, dialectical behavioural therapy, violent reduction programmes, problem solving groups and reflective groups.

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- Staff used a range of recognised rating scales to assess and record severity of symptoms and the outcomes of interventions including; health of the nation outcome scales, the malnutrition universal screening tool, national early warning score tool.
- Records showed there was a clinical audit programme which included; consent to treatment, care records, care planning approach, frequency of ward rounds. Ward team leaders and deputy matrons audited patient records and the results were then discussed in the matrons group for wider learning and assurance before being fed back down to the ward team leaders.
- Patients were offered routine access to national screening programmes such as breast screening (an external service visited), flu vaccinations and cervical screening. Uptake rates for flu vaccinations were 166 (141 men, 25 women) and the number of patients that refused were 145 (121 men, 24 women).
- Cardiac monitoring was offered annually as part of annual health checks to all patients.
- Patients could access some specialist nursing services for example tissue viability, stoma care and diabetic liaison nurses.
- Patients were routinely screened for blood borne viruses on admission.
- Rampton Hospital has a no smoking policy in all areas. Patients who were smokers were prescribed nicotine replacement therapies if required.
- The lead for booking annual health checks, dentist and optician appointments were the physical healthcare team. Whilst this worked well it meant ward staff did not have ready access to when checks were due. This meant that there was not a holistic approach to the patients care at ward level and also meant that patients were unlikely to be aware or encouraged to be involved in their own care regime.
- The physical healthcare team had completed additional training to offer a wider range of skills. This included minor surgery and wound management that meant patients did not have to attend hospital and could be cared for onsite.
- The trust had two different assessment tools in place for the assessment of tissue viability risks. Ward staff using

one tool and the physical healthcare staff using another each with different scoring. The trust advised us they were planning to introduce one tool throughout the service.

- A malnutrition screening tool was in use to assess if patients were nutritionally at risk. Where patients had consented to be weighed these were fully completed however the frequency of weighing patients was not always updated according to increased risk.

## Skilled staff to deliver care

- There were a full range of mental health disciplines working across the hospital. These included, mental health nurses, nursing assistants, learning disability nurses, general nurses, and psychologists, social workers, occupational therapists, psychiatrists, GPs and pharmacists. We were told staffing issues impacted on them delivering effective care at all times.
- All of the staff had appropriate qualifications for their role but there was a vast range of difference in experiences from newly qualified staff to staff that had been qualified over 20 years. We spoke to one member of staff who had worked in the hospital for less than a month and another staff member who had worked there for more than 25 years. This meant that with the movement of staff, there could be some wards with less experienced and newly qualified staff on without more experienced staff members being available to support them.
- Some staff told us they had received specialist training for their role, including training around physical healthcare, self-harm, ensuring boundaries when working with patients. There was also specific staff trained to manage potential riots or dangerous incidents. We were told the personality disorder training for the new staff had been cancelled twice. This meant they were concerned they were not ready to work on these wards.
- Some staff felt they required more training around physical healthcare, in order to feel more confident in supporting the patient in managing their condition. The recent ward managers' development day had a presentation from the physical healthcare matron to discuss the current provision and strategy of the health centre. They aimed to develop a rolling programme of training for ward staff.

# Are services effective?

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- Since the last inspection, 67 staff members had completed training in the harnessing opportunities, protective enhancement system (HOPE(s) model). Staff had also been trained so they could deliver the training to colleagues. This model was developed by another secure hospital and it is a framework that supports the multi-disciplinary team move patients beyond long term segregation.
- Staff told us they have regular supervision and appraisals. In January 2018, the supervision rate was 78.9% against a target of 80%. The overall appraisal rate for non-medical staff was 95 %.
- Senior managers told us they were able to address poor performance promptly and effectively and were currently working towards addressing the sickness levels in the hospital. There five staff suspended between 1 July 2017 and 3 March 2018, one was a qualified nurse and the others were nursing assistants.
- The physical healthcare team had been trained to use equipment that allowed on site testing of blood samples where patients were prescribed Clozapine. This ensured timely testing and results availability.
- Some ward staff told us they felt that they did not always receive training for some of the medical conditions that they supported patients with. An example of this was stoma care. Although, the trust told us that ward staff were directly supported by contracted-in specialist stoma nurses who worked with patients and advised staff and the ward team on the management of individual cases. The amount of movement of staff within the hospital could limit the effectiveness of training for day-to-day management of patients' specific physical health needs.
- We spoke to staff about sepsis training and awareness of the sepsis screening tool. None of the staff we spoke said they had received training or used the tool. We raised this as a concern and the trust responded and said between 11 April 2017 and 11 April 2018, 519 nursing and medical staff had been trained in sepsis. From January 2018 it became a requirement for all clinical and non-clinical staff to receive sepsis training.
- There were regular multidisciplinary meetings held on all of the wards across the hospital. We observed five multi-disciplinary meetings and found they were conducted well and included the patients' views in decision making.
- We did not observe any handovers but staff told us and records showed the handovers included all relevant patient information; risk and safeguarding issues, current presentation and diary appointments.
- Records showed there was good joint working between social workers and the local authority. They met regularly to discuss any safeguarding concerns and as part of the assessment to safeguard children visiting Rampton Hospital.
- We observed ward staff and therapy staff mostly communicated effectively with each other regarding keeping each other up to date with their patients' presentation and care planning.
- Rampton Hospital regularly collaborated with the other secure hospitals. Senior managers told us they were in regular communication with their counterparts in the other hospitals.
- Senior managers told us they worked closely with commissioners and NHS England regularly attended bed management meetings and patient reviews.
- The hospital had an outreach service that visits patients on the waiting list or recently discharged patients and works with the medium secure placement around the care planning and risk management of the individual patient. NHS England told us this team worked well and had been very effective in supporting discharges.
- The physical healthcare team worked across the hospital with ward staff and also with other hospitals regarding patients' outpatient appointments and any physical healthcare needs that could not be met in Rampton Hospital.

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

- Detention paperwork was received and scrutinised by the Mental Health Act administration team. The staff we spoke with knew they could ask this team for further support around the Mental Health Act if required.

## Multi-disciplinary and inter-agency team work

# Are services effective?

Good 

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- The ward staff mostly had a good understanding of the Mental Health Act and at the time of inspection all ward based services had a compliance rate of above the trust target of 80%. The therapies and education department, compliance rate was 78%.
  - Information about consent to treatment and mental capacity assessments were attached to medication charts.
  - Records showed patients had their rights explained to them on admission and then at appropriate intervals and in line with section 132 of the Mental Health Act.
  - We reviewed the seclusion and long term segregation policy which had been implemented in September 2017 and was due to be reviewed on 20th March, during inspection week. Staff told us they were not aware whether the review had taken place or not. The policy was aligned to the current Code of Practice 2015.
  - The policy allowed for weekend reviews of long term segregation to take place over the telephone. It stated that a conversation will take place between the on call responsible clinician and the site manager. Each segregated patient will be discussed to see if there had been any changes in the patients' presentation. This conversation should then be confirmed by email which should be copied to the deputy director of forensic services. This appears to be a sensible approach to the recommendations of the Mental Health Act Code of Practice.
  - The 13 records we looked at showed daily and weekly reviews were not consistently recorded in line with the Mental Health Act Code of practice. Staff were unable to explain why this was the case. The Mental Health Act Code of Practice states where patients are subject to long term segregation, their situation should be reviewed by an approved clinician, who may or may not be a doctor, at least once in any 24 hour period. Such reviews were not always recorded on week-days. Although we accept the rationale for the hospital's different approach over week-end reviews, we saw no evidence in the records that an email had been sent recording week-end conversations between the on-call doctor and site manager. We raised concerns regarding frequency of long term segregation reviews during the last inspection. The trusts' action plan from the previous inspection stated an audit had been completed in January 2018 and found improvements were still required and support would be put in place to ensure compliance.
  - Staff knew the segregated patients well. They were able to explain the rationale in terms of why patients required conditions of long-term segregation. We asked why a segregated patient who spent a significant time out of segregation required long-term segregation. Staff were able to tell us confidently that the patient responded badly to episodes of seclusion when not in long-term segregation. The patient found seclusion distressing. Therefore, long-term segregation was the least restrictive way of managing this patient.
  - Minutes from a recent Safe and Ethical Restrictive Interventions Governance Group meeting showed each patient had been discussed individually and it was evident they were making progress. There was evidence of challenge from the chair. Safeguarding referrals were completed by the safeguarding lead during the meeting. However, we were unable to find evidence in the patients' records that a referral to safeguarding had been made.
  - Section 134 mail monitoring records showed staff did not always inform patients of a decision to withhold an item of mail within seven days. In addition, the section 134 policy was out of date; the provider was in the process of updating the policy at the time of inspection.
- ### Good practice in applying the Mental Capacity Act
- At the time of the inspection the percentage of staff who had completed and were up to date with Mental Capacity Act Training were; learning disability service; 88%, personality disorder service; 87%, Peaks; 85%, women's service, 87%; mental health service, 90%;therapies and education staff, 72% and security staff 77%. The trust target was 80%.
  - All patients at Rampton Hospital were detained under the Mental Health Act so Deprivation of Liberty Safeguards were not applicable.
  - There was an up to date Mental Capacity Act policy and staff could access advice from the Mental Health Act administration team regarding the Mental Capacity Act.

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- The Mental Health Act administration team monitored compliance with the Mental Capacity Act within the hospital.
- The staff we spoke with demonstrated a good understanding of the Mental Capacity Act and its guiding principles and gave us good examples of when they would use the Act to support patients in making decisions. The hospital staff showed they had a good understanding of the patients' needs and wishes, feelings and culture.
- The information recorded in the patient records around mental capacity was variable and information was often

difficult to find in the electronic records system or in the paper records. Where we found a mental capacity assessments; some were very detailed and clearly showed staff assessed capacity to consent on a decision by decision basis, for issues with finances and physical health. We also saw discussions around capacity documented in ward round notes. This was a concern at the last inspection and since the last inspection; the trust has carried out two audits to improve compliance. The trust rated their progress towards this action on their action plan as delayed but with evidence of improvement.

# Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

## Our findings

### Kindness, dignity, respect and support

- Throughout the inspection, across all services, we observed staff interacting with patients in a positive manner. Staff were kind and respectful in their communication with patients. We witnessed one example where a patient had become distressed and the staff used de-escalation techniques to help calm the patient and the incident was resolved successfully.
- Patients told us that their regular staff and named nurses had a good understanding of their needs but staff were often moved between wards and so this meant there was not always a regular member of staff on the ward that knew the patients.
- The majority of patients we spoke to and the information from the comment cards we received were very complimentary about staff, particularly ward staff. Patients' said that; staff go the extra mile; they were helpful and supportive; they feel listened to and respected; they feel involved with their care planning.
- There were a few negative reports from patients who felt some staff bullied them and were disrespectful when speaking to them. One patient complained he was being repeatedly injected in the same site which was causing a swelling and staff did not listen to him when he asked them to change the site. Another patient complained he was repeatedly being served food he was allergic to and then required medication.
- The 2017 patient led assessments of the care environment score for privacy, dignity and well-being was 96.2%. This was higher than last year's score and higher than the national average of 90.6%.
- During the last inspection we commented that we thought dignity could be compromised because in some wards, the external curtains over the observation windows and bathroom could be pulled back by any patient walking down the corridor. The trust had considered this concern but felt there had not been an incident where patient dignity was compromised in this way. Also, the feedback the trust sought from patients was they like the curtains, as the integral blinds make a noise at night time, the curtains have therefore remained.

- We observed pat down searches in the women's service being completed in the communal areas in front of everyone. We felt this could have compromised patients' privacy.
- We observed physical healthcare care being given to nine patients.
- Patients' privacy and dignity was respected and where physical health care was delivered this offered in areas which allowed confidentiality to be protected.
- We observed physical healthcare being given in a compassionate manner to patients.
- Patients were included in discussions and decision making around their physical healthcare. Staff answered any questions that patients asked.
- Where patients had refused physical healthcare interventions this was respected and recorded.

### The involvement of people in the care that they receive

- The patients explained that when they were admitted they were given a tour of the ward and were given information leaflets about what to expect.
- The patients we spoke to felt involved in their care planning and risk assessment. Records were not always clear whether patients had been offered a copy of their plans. We saw some records contained management plans, which were not to be shared with the patient in their best interests.
- Ward round notes and patient records showed discussions between patients and staff regarding their care and risk assessments and families and carers were involved where appropriate. We observed patients in ward rounds being able to contribute effectively to their care planning.
- There was access to Independent Mental Health Advocacy and generic advocacy that patients could self-refer to via an internal telephone system. The trust pay for the Independent Mental Health Advocacy service, it was not funded by the Local Authority. A British Sign Language trained social worker visited the Grampian ward twice a week to advocate for the patients with hearing impairments.

## Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- We observed eight community meetings and saw patients were able to raise questions and concerns and received feedback from previously raised issues.
- There was also a regular patient council held and a representative attended from each ward. Patients reported this system worked well and they felt listened to and confident their issues would be acted on.
- We saw evidence in three records patients had been supported to have an advanced decision in place.
- The trust had a carer champion who was the point of contact for the carers to raise any concerns and held regular peer support days at the hospital, which included discussions around visiting Rampton and hospital tours.
- There was a suggestion box for patients to complete about their experience of the physical healthcare team but there were no comments received in order to evaluate the service offered. The Health Centre Matron was leading a hospital wide consultation on what patients and clinical teams needed from their health centre. The consultation was due to conclude in May.

# Are services responsive to people's needs?

Requires improvement 

By responsive, we mean that services are organised so that they meet people's needs.

## Our findings

### Access and discharge

- Staff from Rampton Hospital completed a pre admission assessment before any patient was admitted to ensure they met the criteria for treatment in a high secure environment. The majority of patients were admitted via the criminal justice system but some were admitted under the civil section of the Mental Health Act and usually came from lower secure hospitals.
- The mean bed occupancy levels over the past 12 months were high. Cotswold, Hambleton, Quantock, Aintree, Kempton, Adwick, Alford, Burn, Evans, Jade, Ruby and Topaz had 100% mean bed occupancy levels. Bonnard was the highest at 112.50% and the lowest mean bed occupancy level was Cheviot at 70%. The other wards had levels of 80% to 95%.
- At the time of inspection there were two women on the waiting list for admission and had been waiting more than a year. Since the last inspection, there had been a death of a patient while on the waiting list. Although the responsibility for the allocation of beds in the women's service sits with commissioners the hospital worked with the commissioners in responding to this incident. They created an outreach service to support the secure units prior to admission and post discharge. There were four patients waiting for male mental health beds at the time of inspection, three were currently in prison and one was in a medium secure hospital. None of the other services had waiting lists.
- The hospital and the commissioner's work together to ensure any barriers to discharge or admission can be resolved in a timely manner.
- Between July 2017 and February 2018, there were 18 delayed discharges. Between February 2017 and January 2018 there were 34 planned discharges.
- The physical Healthcare team were available 8.30 - 4.30 each day, excluding weekends and bank holidays. Outside of these hours ward medical responded to healthcare concerns.
- Patients had access to female and male GPs for routine healthcare appointments.
- Appointments with physical healthcare nurses or GPs were held at the health centre or patients could be seen on ward areas.
- Short notice appointments were available. A referral system was in place and triaging of the urgency of the appointment required took place each morning and as new referrals were received. Ward staff completed referrals by email.
- Some clinics were held as the day service centres as 'well-being days' in an attempt to engage with some patients who were reluctant to engage with the physical health care team.
- Where possible physical health care appointments were made to fit in around patients therapy programmes, however this was not always possible.
- Male and female GPs were available and some female only clinics were held.
- Rampton Hospital has a specialist service for hearing impaired patients. Currently there was no in house provision for audiology as a staff member had recently left.
- Speech and language therapy was available through external referral. We saw records where services had been accessed for patients requiring this.
- There was a significant did not attend rate for physical healthcare appointments. These were displayed within waiting areas at the centre. Since January 2018 until the time of inspection, there had been a total of 4,830 appointments offered and 727 appointments had not been attended. The highest reason for non-attendance was patient refusal at 324. There had not been an escort available to take the patient to the healthcare centre on 48 occasions and on 72 occasions the reason for non-attendance was given as seclusion/observation levels.

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

- There was a full range of rooms and equipment to support treatment and care at the hospital, including a fully equipped gym and swimming pool. There was a therapies and education department which provided chaplaincy and spiritual care, speech and language therapy, occupational therapy, education and

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hairdressing. There was also a library where patients could borrow a wide range of books, audio books and CDs. There was a range of therapy rooms and clinic rooms available.

- The physical healthcare centre had a range of rooms and equipment appropriate to the needs of the service; dietician, podiatry, GP.
- We saw in the health centre that external healthcare contractors use the healthcare system to record their activity, but then also copy and paste their entries into the ward system, so ward staff can see the records. This means that the external contractors had access to the patient's mental health records. The question of confidentiality and patient consent was raised with the information governance manager and she explained the hospital was currently working through information sharing requirements and agreements and ensuring that all scenarios at the health centre were covered by the relevant Information Sharing Agreement and in line with General Data Protection Regulations.
- Most wards facilitated visits in certain areas of the wards; we observed visits taking place in the dining room on one ward. There was a visitor room available within the secure perimeter that was suitable for when children visited. It was painted in bright colours and had toys and activities in suitable for children. There was also accommodation, a short walk from the hospital, for visitors that had travelled far. This was also suitable for children.
- There were phones on all of the wards. They were in communal areas but had a hood to maintain privacy.
- All patients had access to fresh air. The frequency of access depended on the individuals risk assessment and whether there were enough staff to facilitate it. We saw patients with unescorted ground leave walking around the hospital gardens. In December 2017, there were 40 patients assessed as able to have grounds access.
- Patients were able to make hot drinks and snacks during the day depending on their individual risk assessment. At night time, patients were allowed certain drinks and snacks in their rooms depending on risk but staff could make hot drinks for the patients if required.
- Patients were able to personalise their bedrooms depending on what their individual risk assessment allowed them to have in their rooms.
- All patients had lockers in which they could store personal or restricted items.
- Several patients told us they were unhappy with the prices in the hospital shop. For example, a cake had been bought recently was £2 more expensive than it was if bought from a supermarket.
- Out of the 32 comment cards that mentioned shortage of staffing as an issue, 16 specifically referred to activities being regularly cancelled. This included on ward activities like playing pool and off ward activities and access to fresh air. Out of 94 staff that mentioned shortage of staffing was a concern, 22 specifically said activities often get cancelled due to staffing shortages. Out of 48 patients that raised concerns regarding staffing, 15 of them felt that activities were frequently cancelled. Examples of activity cancelled were; art group, church, fresh air and gym.
- There were 23 incidents recorded as disruption to services due to staffing incidents allocated to Diamond Resource Centre or Southwell Centre between 5th January 2018 and 22nd February 2018.
- The hospital explained that one of the factors that impacted staffing was the amount of leave of absences. Between April 2017 and February 2018, the number of leaves of absence per service was; learning disability 107; mental health, 182; personality disorder, 133; women's, 156. Hospital appointment was the most frequent reason for leave of absence and Topaz ward had the highest number of hospital appointments with 35.

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

- The main reception area had a message in British Sign Language that said hello and welcome to Rampton Hospital in British Sign Language, but there was no access or loop-system for hearing aid users. Two of the reception and security staff on duty at the time of inspection, were asked if they had received deaf awareness training and they said no.

# Are services responsive to people's needs?

Requires improvement 

By responsive, we mean that services are organised so that they meet people's needs.

- The reception area and some of the newer areas of the hospital were accessible for people with mobility difficulties.
- Information leaflets were available in a language other than English if required.
- Staff told us that an interpreter for a patient whose first language was not English could be arranged as required. However, we were told there was a need for more frequent British Sign Language interpreters available in the evenings and at weekends so patients with hearing impairments could access a wider range of activities. Patients with hearing impairments were unable to access the rainbow club or church because of a lack of interpreters. This was also a concern at the last inspection.
- One of the patients from Grampian ward told us he had been unable to have direct phone contact with his family (his parents also have hearing impairments) since his admission two years ago. This was because there were no Skype facilities at the hospital to support communication. The Trust has since received approval to commence work on the implementation of Skype at the Clinical Secure Practice Forum for High Secure services in February 2018.
- All of the wards displayed information on patients' rights and treatments and how to complain. On Grampian ward there was no information in British Sign Language format, only English.
- During the last inspection there was a high majority of patients that complained they were bored of the four week menu rotation. During this inspection, we only received two negative comments about the choice of food.
- The patient led assessments of the care environment score for ward food was 88.1%, this was worse than the trust overall and less than the national average of 89.7%.
- There were a number of chaplains available for staff and patients throughout the hospital regardless of their religion or culture. They held regular weekly sessions and drop in sessions.
- Two specialist beds were available at the hospital. For other equipment for example bariatric beds (for heavier patients), hoists and pressure care relieving equipment was accessed on an individual basis and obtained according to need.
- Staff told us about one patient where they were having difficulties obtaining equipment, this was escalated to the trust for review.
- Menus were available in a pictorial format to aid patients choose meals.
- Patients could access aromatherapy services and had individual recommendations recorded for them.

## Listening to and learning from concerns and complaints

- The hospital received 260 complaints between March 2017 and 28 February 2018. Out of these, four had been referred to the Parliamentary Health Service Ombudsman; two required no further action, one was ongoing and one was returned for local resolution.
- The patients we spoke with knew how to and felt confident enough to make a complaint if needed. They received feedback on an individual basis or via their community meetings or patient council. Some patients wondered if their complaints were investigated appropriately.
- We reviewed the minutes of the Forensic Quality Governance Group (includes all forensic services, not all specific to Rampton Hospital) and saw that February's minutes stated not all patients felt their complaints were being taken seriously and in order to assure patients the trust was taking complaints seriously, the trust was reviewing complaints randomly and the outcome of this would be summarised in a report.
- Records showed examples of lessons being learnt and action taken following complaints. For example; following disclosure that an interpreter had not accurately represented a patient, the contract now included a requirement that interpreters are rotated to ensure patients' have an opportunity to make any disclosures.

# Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Our findings

### Vision and values

- The trust's vision was stated as "through partnerships, improve lives and the quality of care". The trust's values were set out in the acronym "positive"; people, openness, safety, involvement, trust, innovation, value and excellence.
- The staff we spoke with struggled to remember what 'positive' stood for but all knew the 'tick' logo. Some staff could explain the trusts vision.
- Staff knew who the majority of the senior leaders were within Rampton Hospital, but not the wider trust. We observed senior leaders walking around the hospital during the inspection and it was apparent that staff knew who the deputy director of Rampton Hospital was and she knew them and had a good understanding of their role on the wards.
- Staff of all grades in the physical healthcare team were not familiar with the trust strategy. There were no local development plans available for the physical healthcare team.
- The physical health strategy was implemented by the physical health lead and overseen by the director of nursing for quality and patient experience.

### Good governance

- As part of the wider trust, the hospital had a good information governance management framework in place. There were dedicated forensic information governance meetings which reported into trust wide meetings which also had forensic staff representation. The committee structure had been consolidated since the March 2017 inspection and now fitted more accurately with the One Rampton Hospital approach.
- The two levels of governance assurance in the committees were chaired by the appropriate executive director, which ensured senior leadership engagement. The trust wide information governance meeting reported into the Finance and Performance committee, which was also a change from last year when this group previously reported to the Quality committee.
- The quarterly divisional information governance report was detailed and presented a clear picture of forensic

activity across the trust, however there was very little Rampton Hospital specific information presented in it. The information governance staff also produced Rampton Hospital specific information and we were shown evidence to prove this and found it to be a comprehensive report on activity and risk.

- The hospital had prepared for the new information governance legislative requirements for trusts, (General Data Protection Regulation) due to be implemented in May 2018. We saw evidence to show there was a robust implementation plan and governance structure in place and it's on track to meet the requirements.
- Mandatory training levels were above the trust target and ward managers had good oversight of who needed to complete training via a dashboard. Ward staff and therapy staff received regular supervision and appraisal.
- Recruitment and retention of staff remained a concern. The trust had implemented several strategies to try and address the issue since the last inspection and we felt there was a positive trajectory of improvement and time needs to be given in order to see if the actions will be effective or not.
- The high level of deployment of staff across the hospital was a concern as it appeared to be having a negative impact on the quality of the patient care delivered and the patients' wellbeing. We would questions whether the strategic staffing review and the staffing tool used were robust enough to give an accurate number of staff required to meet all of the patients' needs.
- Ward managers, deputy matrons and matrons mostly felt they had enough authority to do their job. We felt this was an improvement from last year as they appeared more confident in their roles and responsibilities.
- We were told any risks were raised in ward manager meetings and fed up to deputy matrons and matrons who could submit items to the risk register. We saw that staffing was at the top of the risk register.
- The physical healthcare team had a risk register. Previously dialysis had been offered onsite however this had been suspended and was on the risk register due to concerns about water purification and training.
- The hospital submitted 21 Key Performance Indicators data to the national high secure hospital oversight

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group. These include information about bed occupancy rates, number of delayed discharges, staff vacancy levels, activity rates and incidences of violence to staff and patients.

- There was a trust wide ambition to have no incidents causing severe harm or death and to reduce avoidable harm by 50%. The trust were focusing on reducing; physical assaults, pressure ulcers, medication errors and patient falls.

## Leadership, morale and staff engagement

- We spoke to the Freedom to Speak Up Guardian and she told us she felt the morale of staff was improving and feels there has been a change in culture since the last inspection. She says she has had fewer requests from staff to support with escalating incidents.
- Union representatives felt their relationship with senior managers had improved and staff morale had increased.
- Since last inspection and the introduction of the One Hospital model, the staff we spoke to felt morale was improving across the hospital and it felt less like a blame culture. Some staff remained resistant to changes that had been made, but others were on board and felt the changes had had a positive impact on the hospital as a whole.
- The majority of staff we spoke with felt able to raise concerns without fear of victimisation, which was an improvement since last inspection. There were a few staff that still felt there was a blame culture and their jobs would be at risk if they raised concerns. Staff knew the whistleblowing process.
- Sickness rates had increased since the last inspection and this was being addressed by senior managers. The process of recording sickness was being centralised in order to reduce the administration time for ward managers and for senior managers to be able to monitor compliance with the sickness policy.
- There were some opportunities for development planned. From April 2018, the trust were introducing an accelerated pay banding programme which will support staff on band 2, to develop into potential band 4 nursing associates. Senior managers had received leadership training and some nursing staff had also, received specialist training for their roles.

- The hospital had held several away days since the last inspection, for ward managers, deputy matrons, matrons and site and security managers. The feedback from these was positive and the ward managers had requested they happen more frequently and the senior managers agreed they would happen monthly.
- Since the last inspection, the senior managers and the doctors have started to work more closely together and both sides agree there was better engagement. There were regular meetings held which doctors are supported to attend, although some felt their clinical commitments take priority and not management meetings. Consultants' caseloads had been reviewed but these remained higher than at the other high secure hospitals.
- Staff had a good understanding of duty of candour and explained to patients when something went wrong. For example, we saw there had been a recent medication error, Clozapine had been titrated incorrectly. Records showed the nurse contacted the duty doctor, pharmacy and the site manager. They also explained the error to the patient and apologised and then offered to support the patient if they wished to make a complaint.
- The hospital had held several staff well-being days since the last inspection and planned to hold more. These included massage, staff MOTs and talks about the effects of trauma on anxiety.
- A staff consultation process was underway to establish ideas and views about the physical healthcare team. Findings were not yet available.

## Commitment to quality improvement and innovation

- Brecon ward had been accredited as a psychiatric intensive care ward by the Quality Network for Psychiatrists.
- Digi Dialectical Behavioural Therapy pilot. A media developer and a university worked with the personality disorder wards to design digital resources for patients to help reduce self-harm. All of the graphics were drawn by the patients and the project included patients' stories and poems to help other patients.
- Safe space project. Patients tried to replicate their safe spaces they would like to go to when distressed. For example, an audio of a football match.

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- The library service was about to pilot a scheme supporting patients to record stories for their children. For example, a child would then be able to listen to a bedtime story read by their dad.

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

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

#### Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance