Cygnet Hospital Bury

Quality Report

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

Ratings

Overall rating for this location	**Good**
Are services safe?	**Good**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

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

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

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

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

Summary of findings

Overall summary

We rated Cygnet Hospital Bury as good because:

- During this most recent inspection, we found that the services had addressed the issues that had caused us to rate safe, responsive and well led as requires improvement following the May 2016 inspection.
- The hospital was meeting Regulations 10, 11, 12, 17 and 20 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- The required policies of the Mental Health Act code of practice were in place and complied with the code.
- The hospital had created and implemented an action plan following our last inspection to address the concerns we had raised.
- The registered manager held monthly team briefs with all managers to share learning and changes within the hospital.
- The hospital shared learning from incidents via team meetings and monthly lessons learnt bulletins.
- Managers ensured staff received regular supervision, team meetings and annual appraisal.
- Care plans were accessible for patients.
- Staff were aware of the Mental Capacity Act, Mental Health Act and duty of candour and their responsibilities in relation to these.
- New staff received a comprehensive two-week induction.
- We observed caring and supportive interactions between staff and patients, staff knew the patients well.
- The hospital had made real progress to ensure the care plan documentation was accessible for deaf patients, including recording patients' aims and goals from their reviews to DVD for patients to watch.
- There was a variety of activities available for patients including those that were rehabilitative in focus.
- The hospital was managing complaints well and patients knew how to complain.
- The governance structure was fully embedded with clear lines of accountability and reporting.

However:

- The hospital had not fully achieved the actions in relation to Regulations 9 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- Staff working on Bridge Hampton ward, a ward caring for patients, most of whom had a learning disability, had not received training in learning disability.
- Staff working on Columbus and Madison ward, specialist wards for patients with a personality disorder had low levels of attendance at personality disorder training with Columbus 32% and Madison 37%
- British Sign Language training levels for staff working on the four wards caring for deaf patients was low and meant there would be times where staff could not effectively communicate with patients. This included when deaf patients were secluded on Upper West ward.
- There were inconsistencies in the opportunity for patients to have access to mobile phones that had not been individually assessed.
- Bedrooms on the female wards were locked off for seven hours a day; this meant all patients had to be in the communal area together.

Summary of findings

Contents

Good

Cygnet Hospital Bury

Services we looked at

Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults; Child and adolescent mental health wards;

Summary of this inspection

Background to Cygnet Hospital Bury

Cygnet Hospital Bury is an independent mental health hospital with 167 beds. Funding is primarily from NHS England specialist commissioners. There is a registered manager and a controlled drugs accountable officer in post.

The hospital is registered to provide the following regulated activities:

treatment of disease, disorder or injury;

nursing care;

diagnostic and screening procedures;

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

The nominated individual submitted an application to remove the regulated activity for nursing care the week after the inspection as nursing care is included within other regulated activities.

The hospital specialises in forensic services for people with mental health needs including those who are deaf. In addition, the hospital provides child and adolescent services, primarily psychiatric intensive care services, for patients aged 11 to 18 who require urgent hospital admission due to their mental health needs. The hospital has one locked rehabilitation ward for 12 women; the evidence from this ward will be included in the forensic report.

The hospital has 14 wards, nine forensic wards, four child and adolescent mental health wards and one locked rehabilitation ward. We inspected all 14 wards:

- Buttercup ward, eight beds for females, psychiatric intensive care unit for children and adolescents
- Mulberry ward, 12 beds mixed, psychiatric intensive care unit for children and adolescents
- Primrose ward, 12 beds mixed, psychiatric intensive care unit for children and adolescents
- Wizard House, 10 beds mixed, general child and adolescent ward
- South Hampton ward, 12 beds for women, locked rehabilitation
- Lower West Side, 13 beds for deaf and hearing women, low secure
- Bridge Hampton ward, 12 beds for deaf men who had a learning disability, low secure
- West Hampton ward, 10 beds for deaf men, low secure
- East Hampton ward, 13 beds for men, low secure
- Upper East ward, 13 beds for men, low secure
- Lower East ward, 13 beds for men, medium secure
- Upper West side, 13 beds for deaf and hearing women, medium secure
- Madison ward, 13 beds for men with personality disorders, medium secure
- Columbus ward, 13 beds for men with personality disorders, medium secure.

The hospital had a focused unannounced inspection in February 2015 due to concerns raised regarding the hospital. We issued four requirement notices:

- One requirement notice was in relation to staff failing to complete physical health checks on patients when rapid tranquillisation had been administered. This requirement notice was achieved when we inspected unannounced in January 2016.
- The second requirement notice was in relation to the seclusion rooms and the facilities being fit for purpose. When we inspected in May 2016, seven of the 10 seclusion rooms had works completed on them to have separate toilet and shower facilities to protect people's privacy and dignity. Work was being completed on the other rooms during the inspection in May 2016. We were satisfied that the hospital has met this requirement notice at this inspection.
- The third requirement notice was in relation to the hospital completing risk assessments for staff recruited with a conviction. The hospital had introduced a risk assessment process, however it was not being followed effectively. We issued a warning notice in relation to good governance at the inspection in May 2016. We were satisfied that the hospital has met this requirement notice at this inspection.
- The fourth requirement notice was in relation to governance, ensuring the structure and systems in place provided safe, effective care. We observed positive progress with the new governance structure in

Summary of this inspection

place, with a number of meetings taking place and feeding into the senior management level. However, there was not a system in place to ensure actions set from serious incident investigations were in place and achieved. The flow of information and understanding was evident from board to ward manager's level. Staff on the wards were not always aware of changes and their role in relation to the duty of candour. This was a continued breach and we issued a warning notice in relation to governance at the inspection in May 2016. We were satisfied that the hospital has met this warning notice at this inspection.

The hospital had a second focused, unannounced inspection in January 2016 within the child and adolescent services in response to concerns raised and the increase in incidents including serious incidents. We only looked at the safe domain. We were assured patients were safe; however, we issued two requirement notices:

- The first requirement notice was in relation to seclusion, the hospital did not have a system in place to ensure patients could use the shower and toilet in private and no mitigation was in place. The hospital was not due to complete the actions until 31 May 2016. We were satisfied that the hospital has met this requirement notice at this inspection.
- The second requirement notice was in relation to the seclusion and observation policies not complying with the Mental Health Act 1983 Code of Practice. We reviewed the policies at inspection in May 2016, the observation policy was compliant with the Code of Practice. However, the seclusion policy was not. We also found the Mental Capacity Act policy did not comply with the Mental Health Act 1983 Code of Practice and the hospital did not have a policy in relation to Deprivation of Liberty Safeguards. We issued a warning notice in relation to governance at the inspection in May 2016. Prior to this inspection we requested that the provider submitted their revised policies on seclusion and long term segregation, Mental Capacity Act, Deprivation of Liberty Safeguards, incident reporting and management, safeguarding adults and safeguarding children and young people. We reviewed the policies and found that they were compliant with the Mental Health Act Code of Practice, 2015 and the Care Act 2014. We were satisfied that the hospital has met this requirement notice at this inspection.

The hospital had an announced comprehensive inspection in May 2016. We visited all of the wards. Overall, we rated the hospital as requires improvement. Within the forensic wards and rehabilitation ward we rated the safe, responsive and well led domains as requires improvement, effective domain as inadequate and caring domain as good. Within the child and adolescent mental health wards we rated safe, effective and well led domains as requires improvement and caring and responsive domains as good.

We issued four requirement notices:

- Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect. We were satisfied that the hospital has met this requirement notice at this inspection.
- Regulation 11 HSCA (RA) Regulations 2014 Need for consent. We were satisfied that the hospital has met this requirement notice at this inspection.
- Regulation 18 HSCA (RA) Regulations 2014 Staffing. At this inspection the hospital were providing regular supervision to staff. However, the training levels for learning disability, personality disorder and British Sign Language were low. The hospital had a training plan in place and staff attended learning disability training the week after our inspection. As the hospital had made some positive progress, we have issued another requirement notice for 18 (1) (2) (a).
- Regulation 20 HSCA (RA) Regulations 2014 Duty of Candour. We were satisfied that the hospital has met this requirement notice at this inspection.

We also issued three warning notices on both the provider and the registered manager:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care. The provider was not providing person centred care:

We served a warning notice to be met by 10 October 2016. At this inspection, the hospital had created a protocol for the ordering of aids and adaptations, which the occupational therapy department were aware of and had implemented the action plan from the learning identified from the investigation. Care plans on Bridge Hampton ward were accessible and individualised for the patient population; patients were aware of their care plans and had been involved in their creation. Activities offered were meaningful and included activities of daily

Summary of this inspection

living on South Hampton ward. There were still concerns in relation to the availability of staff that could effectively communicate with deaf patients on Upper West ward. We have issued a requirement notice for 9(1)(b) (3)(b)(c)(d).

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. We served a warning notice to be met by 10 October 2016. We were satisfied that the hospital has met this warning notice at this inspection.
- Regulation 17 HSCA (RA) Regulations 2014 Good governance. We served a warning notice to be met by 10 October 2016. We were satisfied that the hospital has met this warning notice at this inspection.

Our inspection team

Team leader: Sarah Heaton, inspector.

The team that inspected the service comprised an inspection manager, four inspectors, an assistant inspector, a pharmacist inspector, a mental health act reviewer, three experts by experience who had lived experience of mental health service provision, a British Sign Language interpreter, three nurses, an occupational therapist, a psychiatrist, a clinical psychologist, a safeguarding specialist and a social worker. All team members had experience of child and adolescent services, forensic services, rehabilitation services or governance.

Due to the size of the hospital the team split into four teams, each with a sub team leader, one team focused on child and adolescent services, one on low secure and rehabilitation, one on medium secure and one on governance.

Why we carried out this inspection

We inspected this service with a short announcement of less than 24 hours' notice to follow up on the warning notice actions and review the progress made by the service since the last comprehensive inspection of Cygnet Hospital Bury in May 2016.

Due to the size of the service and number of actions at the last inspection, we conducted a comprehensive inspection, visiting all wards and exploring all five key questions at both core services.

We undertook this inspection to find out whether Cygnet Hospital Bury had made improvements to their two core services forensic inpatients/secure service and child and adolescent mental health service since our last comprehensive inspection of the hospital that we undertook in May 2016 where we rated the hospital as **requires improvement** overall.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations including commissioners for information.

Prior to the inspection we requested that the provider submitted their revised policies on seclusion and long term segregation, the Mental Capacity Act, Deprivation of Liberty Safeguards, incident reporting and management,

Summary of this inspection

safeguarding adults and safeguarding children and young people. We reviewed the policies and found that they were compliant with the Mental Health Act Code of Practice, 2015 and the Care Act 2014.

During the inspection visit, the inspection team:

- visited all 14 wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 84 members of staff including the registered manager, the managers or acting managers for each of the wards, clinical managers, clinical service managers, doctors, nurses, occupational therapist, psychologists, social workers and support workers
- spoke with 45 patients who were using the service and spoke with five carers
- completed a short observation for inspection on Bridge Hampton ward. A short observation for inspection is used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves.
- received feedback about the service from a commissioner
- attended and observed seven community meetings and ward based activities
- attended and observed two multi-disciplinary meetings
- looked at 56 care and treatment records of patients
- carried out a specific check of the medication management on all wards and reviewed 105 prescription cards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 45 patients.

Patients were positive about the hospital, reporting it was clean, well maintained and they felt safe there.

We were told that staff were supportive, caring and approachable. Patients reported their physical health needs were being met. Patients felt fully involved in their care, with the creation of their care plans, involvement in meetings and planning aims for the future. Activities participated in included walks, crafts, sewing, college and cooking.

Patients reported concerns about the recent introduction of the smoking ban and patients felt they were not going outside as much as previously. Six patients from the forensic wards said that at times there did not seem to be enough staff to ensure activities took place.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

In the forensic inpatient/secure wards we rated safe as good because:

- The wards were clean and ligature risks were mitigated and staff were aware of the risks.
- Staff managed medicines safely.
- Seclusion rooms had been renovated and met the requirements of the Mental Health Act code of practice.
- Staff managed physical security well.
- Although there were staff vacancies, agency nurses had been block booked on wards to provide consistency for patients.
- There was 100% attendance at the core induction for staff.
- All records reviewed had up to date risk assessments with risk management plans in place.
- Restrictive practices had reduced, the stages approach(which limited patients access to community leave dependant on the number of incidents) had stopped on the female wards and the use of searches on South Hampton ward was individually risk assessed.
- All patients records reviewed had positive behavioural support plans in place that noted what patients triggers were.
- Staff we spoke with were aware of safeguarding and the internal and external processes.
- Incidents were investigated well, with learning shared across the hospital.

However:

- The ligature risk assessment was not available for review on Columbus ward.
- Staff had not taken action when patient fridge temperatures exceeded the recommended temperature range.
- Staff attendance at mandatory training was low at 48% across the adult wards. However, a number of new mandatory training courses had been introduced and the hospital had a plan in place for staff to attend the training.
- There was one example of a cut up strip of tablets on Upper West ward where we could not identify the medicine or the expiry date.
- Records of physical observations post administration of rapid tranquillisation were not available for all episodes on the wards as they were collated centrally.

Summary of this inspection

- There was inconsistency in the completion of the observation records.
- Patients on the female wards had limited access to their bedrooms; the bedrooms were locked off between the hours of 9.30am and 12.45pm and 2pm to 5.45pm.

In the child and adolescents service we rated safe as good because:

- All wards were clean, tidy and in a good state of repair.
- The hospital had renovated the seclusion rooms to meet the requirements of the Mental Health Act code of practice.
- The wards all complied with guidance on same sex accommodation.
- A new protocol was in place regarding the transfer of young people to seclusion, of which all staff we spoke with were aware.
- During our last inspection, we raised concerns regarding the fact that ward managers were managing two wards simultaneously. At this inspection, we found that this had changed; there was now a ward manager for each of the wards.
- Staff monitored and analysed the use of restraint and seclusion, to consider options for reducing these interventions; this was collated monthly in a data pack.
- On wards where there were higher vacancy levels, agency staff had been block booked to ensure continuity for patients.
- Each record reviewed included a risk assessment and risk management plan which were completed to a high standard.
- There was a clear culture of least restrictive practice across all of the wards. We found little evidence of any blanket restrictions.
- The concern raised at the last inspection regarding the monitoring of patients post rapid tranquillisation had been fully resolved at this inspection.
- The service managed seclusion in line with the Mental Health Act code of practice.
- Staff had a good knowledge of safeguarding and positive links with the local safeguarding hub.
- Incidents were investigated well, with learning shared across the hospital.

However:

- There were out of date emergency drugs on Wizard House.
- The hospital did not allow patients to have their own mobile phones on the wards.

Summary of this inspection

- Staff attendance at mandatory training was low at 60% across the child and adolescent wards. However, a number of new mandatory training courses had been introduced and the hospital had a plan in place for staff to attend the training.

Are services effective?

Requires improvement

In the forensic inpatient/secure wards we rated effective as requires improvement because:

- Staff working on Bridge Hampton ward, a ward caring for patients, most of whom had a learning disability, had not received training in learning disability.
- Staff working on Columbus and Madison wards, specialist wards for patients with a personality disorder had low levels of attendance at personality disorder training with Columbus 32% and Madison 37%
- British Sign Language training levels for staff working on the four wards caring for deaf patients was low and meant there would be times where staff could not effectively communicate with patients. This included when deaf patients were secluded on Upper West ward.
- There were inconsistencies in the opportunity for patients to have access to mobile phones that had not been individually assessed.
- Bedrooms on the female wards were locked off for seven hours a day; this meant all patients had to be in the communal area together.
- There was an example on South Hampton ward where staff had not explored the refusal of a patient to have their blood taken for serum monitoring within the multidisciplinary team meeting and recorded in the notes.

However:

- We found detailed, individually specific positive behaviour support plans in place, which would make it easy for new or bank or agency staff to understand how best to support patients.
- All care plans reviewed were up to date and staff had reviewed them within two months prior to the inspection.
- Accessible versions of care plans were in place with the use of “my aim” plans, which included patient’s photographs and the aims and goals for the next six months prior to next review.
- Staff were following national guidance and best practice in relation to medicine prescribing and assisting patients to stop smoking.

Summary of this inspection

- The hospital had introduced and adhered to a protocol in relation to aids and adaptations.
- Clinical or forensic psychologists provided therapy and assessments in all of the adult wards.
- The hospital used a variety of outcomes scales to measure progress for patients.
- Prior to working in the wards, staff received a comprehensive two week induction.
- Staff were receiving supervision, appraisals and team meetings.
- Regular multidisciplinary meetings took place; we observed positive teamwork for the benefits of patients.
- Staff were aware of the guiding principles of the Mental Health Act and Mental Capacity Act and their role in relation to these Acts.
- The provider had reviewed the policies and procedures since the last inspection and met the requirements of the Mental Capacity Act, Mental Health Act code of practice and Care Act.

In the child and adolescents service we rated effective as good because:

- All care records reviewed contained a comprehensive, holistic and timely assessment completed on admission, including their physical health.
- Staff and patients completed assessments together and reviewed them on an ongoing basis.
- A newly appointed pastoral lead was responsible for engaging those patients that may have been out of the education system; spending one to one time with those patients encouraging them to take small steps to engage.
- At our last inspection, we found that although all patients had a positive behavioural support plan in place, these were mostly reactive in nature. At this inspection, positive behavioural support plans gave patients the tools to manage their emotions on a day-to-day basis.
- Antipsychotic medications prescribed were within the children's and young people's British National Formulary limits.
- Since our last inspection, the psychology input across the service was improved.
- Staff used rating scales in order to monitor and record outcomes for patients.
- Staff were receiving supervision, appraisals and team meetings.
- A five-day child and adolescent mental health course for staff had been developed and rolled out at the beginning of 2017.

Summary of this inspection

- Staff had attended training and were aware of the guiding principles of the Mental Health Act, Mental Capacity Act and the Deprivation of Liberty Safeguards and their role in relation to these Acts.
- The hospital had reviewed policies and procedures since the last inspection and met the requirements of the Mental Capacity Act, Mental Health Act code of practice and Care Act.

However:

- Due to the recent introduction of the child and adolescent specialist training there were low numbers of staff completion.

Are services caring?

Good

In the forensic inpatient/secure wards we rated caring as good because:

- Staff knew patients well and were able to support patients in the best way to meet their needs.
- We observed warm, supportive and caring interactions between staff and patients.
- Patients told us that regular staff were respectful and polite including knocking on bedroom doors.
- Staff we spoke with had a clear understanding of patients' needs including their likes and dislikes and how best to support them.
- Information was on display for patients in a format that was meaningful.
- Patients were involved in their care planning. Patients told us and records confirmed that care plans were accessible to individual patients including their own photograph.
- On West Hampton ward, staff had introduced the recording in British Sign Language of the outcomes and actions from individual patients' care programme approach reviews onto a DVD for individual patients to watch.
- Advocacy was available for patients with a diverse range of needs and the providers reflected these.
- All wards had community meetings, and patients had the opportunity to contribute to the Patient recovery outcome meetings and deaf recovery outcomes meeting.

However:

- Nine patients told us that bank and agency staff were not as aware of privacy and respect as regular staff, with occasions where they had entered their room without knocking.
- The provider did not make information available for each ward to orientate patients to the ward.

Summary of this inspection

In the child and adolescents service we rated caring as good because:

- We observed staff interacting with patients in a kind, caring and compassionate way.
- Staff were knowledgeable about the patients they were caring for.
- Patients told us that the staff treated them with kindness and spent one to one time with them when they needed extra support.
- Patients and their carers told us that they felt involved in their care and that staff listened to their contributions.
- Patients told us that they had a copy of their care plans if they wanted them and that they understood what was in them.
- There was a strong culture of patient involvement on all of the wards.
- On admission, patients received an information pack about the ward to assist with orientation.
- Patients chaired morning meetings and reviews.
- Each week there was a community meeting where all staff would attend including the domestic staff and chef.
- Patients from Wizard House had been involved in the recruitment of staff.

Are services responsive?

Good

In the forensic inpatient/secure wards we rated responsive as good because:

- Goals, aims and discharge plans were included in patients' records we reviewed.
- There was a variety of space for activities to take place both on and off the wards.
- The recovery college had started in January 2017 with a variety of courses available to patients.
- Weekly activity planners were in place for each patient with activities reflecting their needs and preferences.
- At the last inspection, we were concerned about the activities available to patients and the appropriateness of them in relation to promoting recovery. At this inspection, we found activities were taking place, which were rehabilitative in focus, with patients on South Hampton ward pursuing between 20 and 26 hours of meaningful activity.
- Patients were able to access drinks freely on the wards and personalise their rooms.

Summary of this inspection

- The service had made reasonable adjustments to make the documentation accessible for patients, with the use of symbols and photographs for the patients with communication difficulties.
- The hospital met the needs of patients with cultural or faith needs by providing appropriate food including halal meat, and access to religious ministers including a Christian chaplain and an Imam.
- The hospitals managed complaints well. Patients knew how to complain and the complaints officer oversaw the investigation of complaints and ensured the hospital followed their complaints policy.

However:

- Information on how to complain was not on display on Lower West ward.
- There was no access to social work on South Hampton ward.
- Patients reported food options were not healthy options and would like chips less often.

In the child and adolescents service we rated responsive as good because:

- Discharges were well planned.
- During our last inspection, we raised concerns regarding the lack of clinic room space across the psychiatric intensive care units. At that time there was only one examination room for all four psychiatric intensive care units and clinic rooms were either too small or shared. At this inspection, there was a clinic room for each ward.
- All of the wards had a range of rooms and equipment to support treatment and care.
- All patients we spoke to told us that the food was of a high quality.
- Patients personalised the wards and their own bedrooms.
- There was a full programme of activities on each of the wards seven days per week.
- A online video calling facility was available for patients to talk to family and friends who were not able to visit.
- Information leaflets were available in different languages for patients or their families whose first language was not English.
- Patients were provided with a variety of information including treatments, activities in the local community and how to complain.
- We saw evidence of interpreters being booked for families at meetings.

Summary of this inspection

- There was access from each ward to a multi faith room where patients could access spiritual support.
- The hospital managed complaints well. Patients knew how to complain and the complaints officer oversaw the investigation of complaints and ensured the hospital followed their complaints policy.

Are services well-led?

Good

In the forensic inpatient/secure wards we rated well led as good because:

- Staff we spoke with knew what the values of the service were.
- Staff reported good support from the senior management team.
- The governance structure was new at the last inspection. At this inspection, we found that the governance structure was well embedded with clear lines of accountability and reporting.
- At the last inspection we found a number of policies were not up to date. Prior to this inspection, we requested that the provider submitted their revised policies; we reviewed the policies and found that they were compliant with the Mental Health Act Code of Practice, 2015 and the Care Act 2014.
- There was clear learning from incidents. The hospital had firmly embedded the system for sharing lessons learned. They shared lessons in a number of ways including via team briefs, team meetings, email, and supervision. Learning was shared across all disciplines.
- The improvements in complaints management, which we saw at the last inspection, had been maintained. Investigations were patient centred and the focus was on learning lessons even where not upheld.
- The hospital had made improvements in how it recruited staff, in files we reviewed hospital policies had been followed and all pre-employment checks completed.

In the child and adolescents service we rated well led as good because:

- Staff we spoke with knew what the values of the service were.
- Staff reported good support from the senior management team.
- The governance structure was new at the last inspection. At this inspection, we found that the governance structure was well embedded with clear lines of accountability and reporting.

Summary of this inspection

- At the last inspection we found that a number of policies were not up to date. Prior to this inspection, we requested that the provider submitted their revised policies, we reviewed the policies and found that they were compliant with the Mental Health Act Code of Practice, 2015 and the Care Act 2014.
- There was clear learning from incidents. The hospital had firmly embedded the system for sharing lessons learned. They shared lessons in a number of ways including via team briefs, team meetings, email, and supervision. Learning was shared across all disciplines.
- The improvements in complaints management, which we saw at the last inspection, had been maintained. Investigations were patient centred and the focus was on learning lessons even where not upheld.
- The hospital had made improvements in how it recruited staff; in files we reviewed hospital policies had been followed and all pre-employment checks completed.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Prior to the inspection, we asked the provider to send a copy of the revised seclusion and long-term segregation policy. We received the policy, dated September 2016. The review of the policy showed that the policy was compliant with the Mental Health Act Code of Practice 2015, which was an action from the warning notice issued from the inspection in May 2016.

During the inspection, we met with the Mental Health Act administration team, spoke to staff and patients on the wards and reviewed paperwork. We noted the hospital had made progress with the implementation of the Mental Health Act since the last inspection. There was an effective Mental Health Act system in place to oversee the administration of the Act, the team had expanded in size to manage the workload and staff received appropriate support and supervision. The senior Mental Health Act administrator completed audits to ensure compliance with the Act, including requesting second opinion appointed doctors.

The Mental Health Act department had developed training to include information on the revised code of practice from 2015, with 100% completed at induction and 7% of staff completion of the refresher training. The physical intervention leads had developed a protocol for the transfer of young people to seclusion within the child and adolescent services, called “protocol for the support and management of service users who require seclusion in Bury CAMHS PICU service”, December 2016.

Mental Capacity Act and Deprivation of Liberty Safeguards

Prior to the inspection, we asked the provider to send a copy of their Mental Capacity Act and Deprivation of Liberty Safeguards policies. We received the policies dated July and September 2016. The policies provided a summary of the legislation, including staff’s role in relation to this with clear flow charts. There was also clear advice for staff as to where they could seek additional information regarding mental capacity. This was an action from the warning notice issued from the inspection in May 2016.

During the inspection, staff we spoke with understood the Mental Capacity Act and the principles of this, including the assumption of capacity.

We reviewed patient records and found an example of positive multi-disciplinary working in relation to the capacity of a patient to consent to a relationship with another patient and their potential vulnerability in relation to this. The hospital had involved the Independent Mental Capacity Advocate for the patient. Staff used a capacity template to ensure they followed the two-stage test of capacity.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Good	Requires improvement	Good	Good	Good	Good
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Overall	Good	Requires improvement	Good	Good	Good	Good

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Good

Safe and clean environment

The low and medium secure units' physical security met the standards set out by the Royal College of Psychiatrists. There was a secure perimeter with anti-climb features. To gain access to the wards you entered via an airlock, within the airlock there was a list of banned items; lockers were available to store items that staff and visitors could not take onto the ward. We toured all ten wards and clinic rooms.

All wards were clean and decorated to a welcoming standard. There were blind spots on the wards; however, the hospital mitigated these by the use of closed circuit television and parabolic mirrors. Nine of the wards had completed ligature risk assessments available to view. Staff on Columbus ward were not aware of the ligature risk assessment. Those updated since December 2016 included the recently identified risk of shower drains.

All wards were single sex; therefore, they complied with the guidance on same sex accommodation.

Clinic rooms were clean and tidy; medicines were stored in alphabetical order and were in date. Emergency medicines were present and in date. Recently introduced emergency response bags were available and replaced the hospital's previous arrangements for separate bags for different emergency items. Staff reported this working well and when they completed the practice drill, it had reduced the response time for starting resuscitation.

Since the last inspection, the hospital had renovated the seclusion rooms. At the last inspection we were concerned as to how staff protected patients' privacy and dignity when using the shower and toilet facilities whilst in seclusion, this had been fully resolved.

They had two-way communication systems, air conditioning, externally controlled lighting, allowed clear observation and had separate toilet and shower facilities and a means for patients to orientate themselves to time with a clock and access to daylight. The rooms met the requirements of the Mental Health Act code of practice.

Staff adhered to infection control principles; hand sanitizer was available at the entrance to each ward. A concern highlighted at the last inspection was some staff had long varnished fingernails, which could pose a risk to patients if involved in physical interventions and for infection control principles. We did not see any staff with long painted fingernails at this inspection. Ward domestics were visible on each ward; we reviewed three cleaning rotas, which were all up to date.

Appliances had been portable appliance tested; we reviewed records to confirm this occurred, as stickers were no longer placed on items. Staff measured fridge temperatures; all medicines fridges were within range however, one patient fridge on South Hampton ward exceeded the recommended temperature on several occasions, we highlighted this with staff and they arranged to rectify the situation.

All staff had alarms; the hospital also provided the inspection team with these. Patients had nurse call bells in their bedrooms. There had been an incident where a nurse call bell had not been working when a patient tried to use

it. Learning from this was to ensure that staff tested these as part of their security checks to avoid this happening again. Records we reviewed confirmed staff were checking that the nurse call buttons were working.

Safe staffing

The hospital used bank staff and agency staff when they could not fill vacant shifts with permanent staff. The number of shifts covered by bank and agency staff from November 2016 to end of January 2017 was:

- Bridge Hampton 485
- Columbus 570
- East Hampton 210
- Lower East 437
- Lower West 415
- Madison 558
- South Hampton 106
- Upper East 321
- Upper West 678
- West Hampton 125

For the same time period, the number of shifts not filled by bank and agency were:

- Bridge Hampton 3
- Columbus 5
- East Hampton 3
- Lower East 1
- Lower West 2
- Madison 4
- South Hampton 1
- Upper East 1
- Upper West 3
- West Hampton 1

Staffing establishments for the wards(including vacant posts) are:

Qualified nurses:

- Bridge Hampton 6.9
- Columbus 6.9
- East Hampton 6.9
- Lower East 6.9
- Lower West 6.9
- Madison 6.9
- South Hampton 5.8
- Upper East 6.9
- Upper West 6.9
- West Hampton 6.9

Support workers:

- Bridge Hampton 28.1
- Columbus 22.4
- East Hampton 17.7
- Lower East 22.4
- Lower West 24.7
- Madison 22.4
- South Hampton 18.9
- Upper East 17.7
- Upper West 24.7
- West Hampton 15.4

Vacancies for the wards, as of February 2017:

Qualified nurses:

- Bridge Hampton 2
- Columbus 1
- East Hampton 2
- Lower East 4
- Lower West 2
- Madison 3
- South Hampton 2
- Upper East 2
- Upper West 3
- West Hampton 2

Support workers:

- Bridge Hampton 8
- Columbus 10
- East Hampton 6
- Lower East 7
- Lower West 6
- Madison 8
- South Hampton 8
- Upper East 6
- Upper West 7
- West Hampton 2

Staff sickness and turnover rate from February 2016 to January 2017 is:

Sickness:

- Bridge Hampton 4.7%
- Columbus 3.7%
- East Hampton 1.6%
- Lower East 2.6%
- Lower West 4.2%
- Madison 2.9%

- South Hampton 2.2%
- Upper East 5.8%
- Upper West 6%
- West Hampton 2.1%

Turnover:

- Bridge Hampton 2.8%
- Columbus 3.9%
- East Hampton 4.6%
- Lower East 3.7%
- Lower West 5.7%
- Madison 3.8%
- South Hampton 0.5%
- Upper East 5.5%
- Upper West 4.7%
- West Hampton 2.3%

The registered manager, the operations director and staff from other hospitals within the same provider met regularly to discuss staffing levels across the provider. The registered manager advocated for an additional qualified nurse to work night shifts to cover the breaks for qualified staff, which was agreed. The hospital started recruitment meetings in January 2017 with the clinical managers, medical director and general manager to discuss staffing across the site. The numbers of patients on the ward and the level of patient observations determined the number of staff on shift.

Agency nurses had been block booked on wards to provide consistency for patients. Agency staff we met knew the ward and the patients well. South Hampton ward used a staff orientation sheet to assist staff with information regarding patients' needs, activities and other useful information.

Ward managers were able to contact the staffing coordination department when additional staff were needed to cover, including when patients' required additional observation or support to go on home leave.

All wards apart from South Hampton ward had two qualified staff on shift during the day, South Hampton had one qualified staff on. We saw qualified nurses in the communal areas interacting with patients and staff.

We reviewed the registers of cancelled leave from November 2016 to end of January 2017 and found seven examples of cancelled leave due to the staffing levels across Lower West ward, West Hampton ward, Bridge Hampton ward, East Hampton ward and Upper West ward. The hospital provided rearranged dates for six of the cancelled leaves. The hospital could not rearrange one of the leaves as it was to a specific activity of the deaf club.

There were enough staff to carry out physical interventions; if additional staff were needed, the alarms were activated and the response team attended.

There was an on call rota showing which doctors were on call. If needed and they were not on site, doctors would come into the hospital when on call to provide medical support. Facilities were available on site if doctors needed to stay over when on call.

Since the last inspection the general manager had completed a review of the training provided, enhanced the training available, and introduced a new training system to hold accurate data, introduced in December 2016. Mandatory training for the hospital included medicines, prescriptions and administration, side effects, basic life support, hands off; reducing restrictive practice, immediate life support, information governance, management of actual or potential aggression, safeguarding, the Mental Health Act and a security refresher. If staff worked on a ward supporting deaf patients, British Sign Language levels one and two were mandatory. If staff worked on a ward supporting patients with a learning disability or personality disorder, training in this topic was mandatory. Overall training compliance was low with an average of 48% compliance across the adult wards. However, a number of courses had recently been introduced including eLearning for medicines and information governance and face to face training of reducing restrictive practices and staff were booked on the courses. There was 100% attendance at the core induction, which was two days long. This covered complaints, duty of candour, equality and diversity, fire, fluids and nutrition, information governance, mental health awareness including the Mental Capacity Act, safeguarding adults and children level one and security. In addition to this staff that were ward based attended a two week induction which included management of actual and potential aggression.

Training levels for immediate life support was:

- Bridge Hampton 76%
- Columbus 79%
- East Hampton 60%
- Lower East 55%

- Lower West 56%
- Madison 79%
- South Hampton 81%
- Upper East 61%
- Upper West 80%
- West Hampton 62%

This meant that on average across the adult wards 69% of staff had received training in how to respond to emergency medical situations.

Training compliance levels for management of actual and potential aggressions was:

- Bridge Hampton 84%
- Columbus 79%
- East Hampton 70%
- Lower East 70%
- Lower West 78%
- Madison 95%
- South Hampton 88%
- Upper East 78%
- Upper West 84%
- West Hampton 71%

This meant that the majority of staff knew how to respond safely and appropriately to patients who may present behaviour that challenges or be physically aggressive.

Assessing and managing risk to patients and staff

We reviewed data provided by the hospital in relation to use of seclusion and restraint and found that Bridge Hampton and Columbus wards had used seclusion once in the six months from August 2016 to end of January 2017. Upper East side had used seclusion three times, Lower East side nine times, Madison 12 times, Upper West side 17 times and the highest was Lower West with 27 times. West Hampton, South Hampton and East Hampton had not used seclusion.

In relation to restraints, we found all wards except East Hampton had used restraint during the time August 2016 to end of January 2017. However, West Hampton had only used it once, Columbus had used it three times, Upper East side four times, Madison seven times, Lower East side nine times, South Hampton 12 times and Bridge Hampton 33 times. The highest use of restraint was the female wards with Lower West side 163 times and Upper West Side 261 times. The hospital analysed restraint data on a monthly basis, shared a "restrictive intervention data report" with each ward, and expected the ward managers to complete a narrative as to the reasons for the figures. Restraint data was analysed in relation to holds, positions, time of day, day of the week and debriefs completed. We raised concerns with the managers at the hospital regarding the female wards and the approach of locking off the bedroom corridors for significant times of the day, the expectation was that the patients were in the communal area together which could have affected the behaviour exhibited by patients. Following the inspection, the hospital has reviewed this practice and staff were no longer locking off the bedroom corridors.

Within the six month period, four of the adult wards had used prone restraint. Madison once, Lower West side twice, Lower East side three times and Upper West side 31 times. Prone restraint is where a patient when restrained, is on the floor face down. This position presents a risk to patients for possible positional asphyxiation. However, staff advised that although a patient may go down onto their front, staff turned them over straight away. The hospital recorded all restraints including prone restraints on their electronic incident recording system. Ward managers received monthly restrictive interventions data packs where the hospital collated and analysed the data with the aim of reducing restrictive interventions. Managers also discussed the use of restraint at morning managers meetings.

We reviewed 34 care records. The hospital used the Salford tool for the assessment of risk. All records had up to date risk assessments with risk management plans in place, including safeguarding plans for those vulnerable patients where these were risks associated with other patients. Patients were involved in the creation of these and had signed the assessment, if a patient declined to sign; staff noted this on the document. Patients also had historical clinical risk management 20 assessments in place, which psychology staff completed. Some of the assessments were under review and the psychology team had prioritised patients according to presentation and current circumstances.

At the last inspection, we were concerned within the female wards of the use of the stages approach (this approach reduced patients community leave and access to their bedrooms if they had been involved in an incident), and the use of searches within the rehabilitation ward. At this inspection, we were pleased to see that the stages approach had stopped on the female wards, the use of

searches on South Hampton ward was individually risk assessed, and no current patient was subject to regular searches. However, patients on the female wards had limited access to their bedrooms; the bedrooms were locked off between the hours of 9.30am and 12.45pm and 2pm to 5.45pm. We raised this with the registered manager at feedback. Following the inspection, the hospital has reviewed this practice and staff were no longer locking off the bedroom corridors.

There were inconsistencies in the opportunity for patients to have access to mobile phones. Deaf patients had mobile phone access in Lower and Upper West wards, whereas hearing patients could only take mobile phones when out on leave. Patients on West Hampton, a ward for deaf males had mobile phones. Patients on South Hampton, the rehabilitation ward had access to mobile phones. East Hampton ward was the pilot ward for patients to have hospital provided mobile phones, with pre-programmed numbers in that patients could contact, however they could not text from the phone. The other five adult wards had not introduced the possibility of access to mobile phones. We raised the inconsistency of the use of mobile phones with the registered manager at the feedback session. In the week following the inspection, they wrote a use of mobile phones protocol and shared it within the hospital. This meant patients would be individually risk assessed as to the possibility of them having access to mobile phones, in conjunction with the provider's policy "service user access to telephones and mobile devices", August 2016, which states access to devices should be individually risk assessed by the multidisciplinary team.

We reviewed observation records on South Hampton, West Hampton and Upper West wards and found inconsistency in the completion of the records; some staff signed across the whole line and others in individual boxes. There was also a variety of observation documents to complete depending on the level of observations for patients. The current system could be confusing for staff.

Staff we spoke with advised that restraint was used as a last resort, all patients had positive behavioural support plans in place which noted what patients triggers were and how best to support people through the red, amber and green stages of their behaviour. The hospital had embedded the recommendations of See Think Act second edition, 2015, produced by the Royal College of Psychiatrists Quality Network for Forensic Mental Health Services. Staff were following the guidance of ensuring good relational security of the team, other patients and both the inside and outside world.

Recently the hospital had introduced the inclusion of oral as and when required tranquillisation medication to the requirements of monitoring post administration. This was in addition to the recommendation in NICE guideline '[NG10]: Violence and aggression: short-term management in mental health, health and community settings May 2015', which advises monitoring post intramuscular administration of rapid tranquillisation. All staff we spoke with were aware of the changes. We reviewed physical observation forms post administration of rapid tranquillisation on Madison ward and found that they were not all available to review as staff had sent them to a central department in the hospital for inputting to the electronic records system. Staff did not keep copies on the ward. The records we reviewed, staff had completed fully.

We reviewed seclusion records and found that staff had completed them fully, with a seclusion care plan in place and staff terminated seclusion at an appropriate time.

Staff we spoke with were aware of safeguarding and the internal and external processes and they were able to provide examples of recent safeguarding alerts. For patients who were vulnerable to exploitation or targeting from other patients, safeguarding care plans were in place. All staff had attended the safeguarding children and vulnerable adults within their induction. We reviewed the course content, which included information on more recent safeguarding concerns of human trafficking and PREVENT (government's counter-terrorism strategy) and female genital mutilation, plus staff responsibilities and how to report a safeguarding concern.

We reviewed 105 prescription cards and all clinic rooms and medicine stock. We found on Upper West ward a partial strip of medication that had been cut, which did not include the name of the medication or the expiry date and this posed a risk to staff and patients of the possibility of patients receiving the wrong medicine. The medicine had not been administered. It had been brought to the ward during the night after they had used the last of their stock of the medicine. We highlighted this with staff who disposed of the medicine safely.

Good

Forensic inpatient/secure wards

Facilities were available off the ward for children to visit patients with a family visiting room, which was welcoming and appropriate for the purpose.

Track record on safety

The number of serious incidents from February 2016 to January 2017 in the adult services was 28.

We reviewed three specific incident investigations from adults, which showed that staff investigated incidents well. The investigator identified local actions, staff carried these out, and where appropriate learning shared across both adults and child and adolescent services. The hospital supported staff and patients and reflective practice encouraged.

An example of improvements in safety as a result of learning from a serious incident was where a young person ligatured from a shower plug hole and as a result this was added to all environmental risk assessments and shared with staff across the hospital to ensure extra vigilance.

Reporting incidents and learning from when things go wrong

Staff were aware of what constituted an incident or accident and how to report. The provider used an electronic incident reporting system. Ward managers and senior managers discussed incidents at the daily morning meeting. The hospital also submitted regular safeguarding notifications to CQC, including patient on patient incidents.

At the last inspection we were concerned, as the hospital were not sharing lessons learnt across the hospital, staff were not aware of learning from adolescents' service to the adults' service. However, at this inspection, the hospital was sharing learning from incidents via the lessons learnt bulletin, this was emailed to all staff, and a laminated version was given to all wards to put on the back of the office door for staff to read and refresh their knowledge of. We saw the most recent bulletin on the back of office doors and were also shown a file with previous lessons learnt bulletins in for staff to refer to. Lessons learnt was also an agenda item in supervisions and in team meetings of Lower East, Bridge Hampton, Lower west, West Hampton, South Hampton, Upper West and Columbus wards. Staff we spoke to were able to share lessons learnt in other parts of the service and reported how helpful it was.

From the last inspection, we were concerned as the learning from a serious incident regarding staff exiting seclusion safely was not included in the physical intervention training. However, at this inspection we reviewed training material and found that it was now included in the training, therefore the hospital had met this part of the warning notice.

A recent learning that staff shared was in relation to a patient using the shower plughole as a ligature point within the child and adolescent services. The hospital had shared this with adults' services via the lessons learnt bulletin and the environmental risk assessments had been updated accordingly to ensure staff were checking the shower plugholes and had increased vigilance of this.

Staff told us and records confirmed that debriefs took place following incidents. Debriefs took place for both staff and patients.

Duty of Candour

Staff we spoke to had an understanding of duty of candour at a level appropriate to their role. Ward managers were aware of the duty of candour and their role in relation to apologising. We reviewed an incident on Bridge Hampton ward where a member of staff apologised to a patient for a medication error that had occurred.

Staff received training in duty of candour at induction. There were effective systems in place for identifying whether an incident reached the duty of candour threshold and monitoring that the actions were taken. There had been no further incidents within the adult's services since our last inspection that reached the duty of candour threshold.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed 34 care records. Prior to admission, two staff from the hospital, usually a doctor and a nurse completed an initial assessment. Upon admission, a nurse completed a 72-hour care plan and then as the admission progressed detailed care plans were created with the patient.

Good

Forensic inpatient/secure wards

We found detailed, individually specific positive behaviour support plans in place, which would make it easy for new or bank or agency staff to understand how best to support patients.

All care plans were up to date and staff had reviewed them within two months prior to the inspection. Staff routinely reviewed them every six months in line with their care programme approach reviews or earlier if patients' needs changed.

We found evidence in 19 out of 34 patient records of full physical health examinations upon admission and all records had evidence of ongoing physical health monitoring including annual health checks. Accessible plans called "help me stay well" were in use on West Hampton ward and included medication and triggers to deterioration. We saw an example of a person centred care plan for psychotropic medication, including an explanation of why the individual was taking the medication, written in the first person with short term and long term goals which was signed by both the patient and staff. The hospital supported patients to access the dentist.

Accessible versions of care plans were in place with the use of "my aim" plans, which included patient's photographs and the aims and goals for the next six months until the next care programmes approach review. Pictorial timelines were in use on Bridge Hampton ward to assist patients with their understanding of their past life events and timescales. At the last inspection, we were concerned, as staff had not created the care plans in a way that patients could easily understand on Bridge Hampton ward; at this inspection, they were accessible with the use of patients' photographs and symbols. We were satisfied that the hospital had met this action.

The four wards caring for deaf patients used the "all about me" recovery-focused documentation. This had eight domains, which were communication, identity, my mental health, problems, rights, services, information and healthy living.

Records were paper based; the incident reporting was on an electronic system. Records were stored in the nurses' office, which staff kept locked at all times to ensure that patients' information was secure and kept confidential.

Best practice in treatment and care

Following the last inspection, we were concerned about the lack of monitoring of serum levels for patients prescribed anti-psychotic medication that had reduced or stopped smoking as this can have an impact on the effect of the medicine. This is recommended by National Institute for Health and Care Excellence guidance 'psychosis and schizophrenia in adults: prevention and management [CG178]', published February 2014. The hospital became smoke free on 1 February 2017. We reviewed six records of patients who had stopped smoking on South Hampton ward and found the hospital staff were completing weekly monitoring. However, in one record, the patient had refused to have their blood taken and staff had not captured any discussions or plans regarding the patient in the multidisciplinary notes The hospital had a protocol for smoking cessation, dated November 2016. The hospital had good systems in place to collate and review the information. Staff were able to identify all patients that were taking clozapine and could provide a base line serum reading and evidence of regular reviews. We were satisfied that the hospital had addressed this action.

Where possible, staff supported patients to access healthcare in the local community including access to the local acute hospital and dentists. The hospital had a physical healthcare team. They were responsible for overseeing the weekly blood tests and reviewed patients post incidents to ascertain if there were any physical health needs. The occupational therapy department provided smoking cessation groups support prior to going smoke free, as recommended in National Institute for Health and Care Excellence public health guideline PH10 'stop smoking services', updated November 2013.

At the last inspection, we issued a warning notice as an occupational therapist had assessed one patient in June 2015 as requiring aids and adaptations for a physical health condition. By the time of our inspection in May 2016, they had not received the equipment. We received confirmation that the equipment was installed in September 2016. The hospital had completed a root cause analysis of the incident and an action was to develop a protocol between the physical health department and occupational therapy department for the identification and assessment for specialist physical health needs. We reviewed the protocol, dated September 2016 and occupational therapists we

spoke with could give examples where the hospital had provided additional equipment for patients including an alternative bed. We were satisfied that the hospital had met this part of the warning notice.

Clinical or forensic psychologists provided therapy and assessments in all of the adult wards. Assistant psychologists supported psychologists in all wards except Lower East. Psychology provision varied with the lowest whole time equivalent of 0.6 in Lower East ward and the highest on Madison of 2.1. The other adult wards received the equivalent of one whole time psychology post. The psychology department were reviewing recognised assessments of violence and risk called historical clinical risk management 20 for individual patients. Staff and patients discussed access to psychology at the multidisciplinary meetings. One to one therapy offered included cognitive behavioural therapy and dialectal behavioural therapy informed interventions. The psychology department had facilitated a substance misuse group with weekly sessions. However, this had ended in January 2017. Drop in sessions were available on wards, psychologists from East Hampton advised topics included coping skills, bereavement, going on home leave. Therapy offered met the recommendation of National Institute for Health and Care Excellence guidance 'psychosis and schizophrenia in adults: prevention and management. [CG178]', published February 2014. This recommends the provision of cognitive behavioural therapy. The guidance also suggests art therapy and whilst the hospital did not employ specific art therapists, a variety of art activities were available to patients, a number of which we observed during the inspection, which promoted creative expression.

Staff told us and records confirmed that occupational therapy staff completed health of the nation outcomes scales for patients, which were created by the Royal College of Psychiatrists as a measure of the health and social functioning of people with severe mental illness. Occupational therapists also completed the assessment tool model of human occupation screening tool. These gain an overview of the patient's occupational functioning.

A variety of clinical audits took place, including the analysis of the incidents, restraints, use of rapid tranquillisation and the possible reasons for these in the monthly restrictive intervention data packs. Ward managers completed audits of staff clinical and line management supervision. Infection control audits took place with clear actions plans with specific timescales. A visiting pharmacist completed a weekly review of prescription cards. The hospital had introduced "See and sign" forms for new policies that were in use across the hospital. Staff signed these forms to confirm that they had read the policies.

Skilled staff to deliver care

The range of disciplines working into the adult wards included psychologists, occupational therapists, nurses, doctors and a pharmacist. There were 11 social workers working across the hospital. Therefore, each ward did not have their own social worker but they had a named social worker for support with tribunals, care programme approach reviews and multidisciplinary meetings. However, on South Hampton ward there was no social work provision; this was due to the funding of the service. This may have an impact on future plans for patients and the connections with their home area.

Staffs' experience was appropriate to the setting and included forensic services and substance misuse services. The hospital offered leadership training for ward managers.

Prior to working on the wards, staff had a two week induction, which was classroom based. The induction included meeting the hospital director and training in security, fire, safeguarding children levels one and two, safeguarding adults levels one, two and three, duty of candour, complaints handling, Mental Health Act and Mental Capacity Act, mental health awareness, managing risk, immediate life support, management of potential and actual aggression, equality and diversity, information governance and record keeping. The induction modules cross-referenced to the care certificate standards. At the end of the two weeks, staff spent a couple of days shadowing staff that are more experienced prior to being included in the numbers on shift.

When we last inspected, staff were not receiving regular supervision and records of supervision were not available. At this inspection, we reviewed staff supervision records and found staff were receiving line management supervision every four to six weeks. The provider's supervision policy, dated January 2016, advised that managerial supervision should be monthly and staff were receiving supervision as stated in the policy. The agenda

included 'how are you', attendance and reliability, training needs and progress, progress in relation to the values of the hospital: care and compassion, competence and communication, courage, and sharing lessons learnt.

At the last inspection, staff were not always receiving appraisals. At this inspection, 91% of nursing staff had received appraisals. The figure was 88% for adult services. All doctors were up to date with appraisals.

We reviewed team meeting minutes for the last six months and found that staff meetings were taking place every one to two months. Since December 2016, ward managers were holding two meetings per month to ensure staff on the different shift patterns could participate. Agenda items included governance updates of lessons learnt, content of the monthly team brief sessions facilitated by the hospital director highlighting progress made and changes within the hospital, policy updates, reducing restrictive practices, staff support and infection control.

At the last inspection, we issued a requirement notice as staff had not received specialist training in personality disorder and there were two wards specifically caring for patients with a personality disorder. At this inspection, training levels for the two specialist wards was Columbus 32% and Madison 37%. Therefore, staff still did not have the knowledge or skills to effectively support this group of patients. The hospital advised since the inspection that a number of staff had been booked on the training. Once completed, this would increase compliance to Columbus 74% and Madison 100%. Staff had not received training in learning disability and on Bridge Hampton ward; the majority of the patients had a learning disability. At this inspection, staff caring for patients on Bridge Hampton ward had not received training in learning disability; the training department had planned for the course to start in March 2017. However, following the inspection, 69% of staff received an introduction to learning disability until they attended the more detailed training.

Four wards cared for deaf patients. At the last inspection, the clinical services manager was only trained to British Sign Language level one and 59% of staff working on Upper West had received British Sign Language level one, meaning staff could not effectively communicate with patients and their colleagues who were deaf. Interpreters were routinely available between 7am and 7pm Monday to Friday. At this inspection, we were still concerned about the availability of staff that were fluent enough to support the deaf patients effectively. Training compliance for British Sign Language for the wards caring for deaf patients was:

Bridge Hampton ward Level 1: 73%, Level 2: 60%

Lower West ward Level 1: 40%, Level 2: 16%

Upper West ward Level 1: 43%, Level 2: 22%

West Hampton ward Level 1 62%, Level 2 38%

A number of staff had been booked on the training and compliant and enrolled figures were provided as:

Bridge Hampton ward Level 1: 87%, Level 2: 60%

Lower West ward Level 1: 84%, Level 2: 16%

Upper West ward Level 1: 70%, Level 2: 39%

West Hampton ward Level 1 100%, Level 2 46%

This meant that there would be times when staff could not effectively communicate with patients, understand their wants and needs, and respond appropriately. We raised this concern with the registered manager at the end of the inspection. Since the inspection, the hospital have submitted an action plan with the availability of interpreters increased, there is also a plan in place to provide bespoke training in relation to British Sign Language signs related to mental health that would improve the communication and assessment skills of staff when caring for deaf patients.

Multidisciplinary and inter-agency team work

Regular multidisciplinary meetings took place weekly to review the needs and progress of patients. We observed two multidisciplinary meetings. We found that staff from all disciplines were actively involved in the meetings, with clear actions and goals from the meetings. Staff knew patients well and treated them with respect. They ensured the meeting was as conducive as possible for patients to participate, listening to patients' contributions and checking patients' understanding of the meeting content. Interpreters advised that they were booked for all multidisciplinary meetings for deaf patients.

Handovers took place between shifts. We reviewed handover notes on East Hampton ward and found that staff discussed the mental state, physical health, section 17 leave, level of observation and the level of risk for all patients and noted for the next shift.

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

The organisational induction included a brief overview of the Mental Health Act, which all staff attended prior to working on the wards. The hospital had recently introduced Mental Health Act refresher training. Adult wards that had attended this so far and levels of attendance were:

Columbus ward 16%

Lower East ward 15%

Lower West ward 4%

Madison ward 5%

South Hampton ward 19%

Upper East ward 17%

Although refresher training rates were low, staff we spoke with were able to describe the basic principles of the Act and explain their role in relation to this, including ensuring patients understand their section 132 rights, referring patients for advocacy and preparing for patients to go on section 17 leave, including assessing their mental state.

At the last inspection, we issued a warning notice, as several policies did not meet the code of practice 2015. Prior to this inspection, we requested that the provider submitted their revised policies on seclusion and long term segregation, Mental Capacity Act, Deprivation of Liberty Safeguards, incident reporting and management, safeguarding adults and safeguarding children and young people. We reviewed the policies and found that they were compliant with the Mental Health Act Code of Practice, 2015 and the Care Act 2014. Therefore, the provider had met the action from the warning notice issued from the inspection in May 2016.

The provider was not following their absent without leave policy at the last inspection; we did not find any concerns with the adherence to the policy at this inspection.

The independent mental health advocate's details were displayed on each ward, including a photograph of the advocate on most wards. There were three different advocacy providers for the hospital to meet the specific needs of patients, including women and deaf patients.

When the hospital admits a patient, the Mental Health Act administrators sent a section 132 form and contacted the ward. If staff did not adhere to the dates for section 132 rights, the Mental Health Act administrators would highlight this on the weekly ward view. If not addressed, the Mental Health Act administrators would escalate this to senior managers. Section 132 information was available in a variety of languages. The communication specialist was available to support giving this information to deaf patients. A DVD of staff that patients knew, signing this information was available and staff could facilitate the viewing of this on a one to one basis. For deaf patients, interpreters were present for all tribunals, manager's hearings and three monthly rights.

During the inspection, we met with the Mental Health Act administration team, spoke to staff and patients on the wards and reviewed paperwork. We noted the hospital had made progress with the implementation of the Mental Health Act since the last inspection. There was an effective Mental Health Act system to oversee the administration of the Act, the team had expanded in size to manage the workload and staff received appropriate support and supervision. The senior Mental Health Act administrator completed audits to ensure compliance with the Act, including requesting second opinion appointed doctors.

Copies of patients' detention papers and other records including section 17 leave forms were available in the files we reviewed.

At the last inspection, we were concerned, as a deaf patient on Upper West ward had not had an interpreter present on two occasions for their seclusion review. At this inspection we learnt that an out of hours interpretation service had been commissioned in February 2017 whereby an urgent interpretation request could be submitted; however, the provider had a window of one hour to ring the hospital back and it was subject to availability. Hospital employed interpreters could be booked to work evenings and weekends, in advance. We noted that a support worker who did not know any British Sign Language was observing a deaf patient on Upper West ward, who was in seclusion. Therefore, the member of staff could not respond to any

communication initiated by the patient or ask questions regarding their wellbeing and mental state,meaning the staff member could not effectively monitor and care for the patient.

Good practice in applying the Mental Capacity Act

There was 100% attendance at the core induction, which was two days long. The induction included training on the Mental Capacity Act. We reviewed the content of the training, which included the five statutory principles. The hospital had commissioned training from a legal expert in the Mental Capacity Act, who provided training to medical staff, ward managers and Mental Health Act administrators in 2016. The course was at a higher level than the one provided at induction. There were plans to offer this course to ward based staff in 2017. Current attendance figures were Bridge Hampton ward 33% and Lower West ward 20%, with further staff nominated for future courses.

Prior to the inspection, we asked the provider to send a copy of their Mental Capacity Act and Deprivation of Liberty Safeguards policies. We received the policies dated July and September 2016. The polices provided a summary of the legislation, including staff's role in relation to this with clear flow charts. Also, clear advice for staff as to where they could seek additional information regarding the topic. This met the action from the warning notice issued from the inspection in May 2016.

During the inspection, staff we spoke with had an understanding of the Mental Capacity Act and the principles of this, including the assumption of capacity.

We reviewed patient records and found an example of positive multidisciplinary working in relation to the capacity of a patient to consent to a relationship with another patient and their potential vulnerability in relation to this. The hospital had involved the independent mental capacity advocate for the patient too. Staff used a capacity template to ensure they followed the two-stage test of capacity.

Capacity to consent to treatment was assessed by the responsible clinician at admission, then reviewed on a three monthly basis. The senior Mental Health Act administrator conducted a full site audit once every quarter, visiting all wards and reviewing the Mental Health Act detention paperwork. As part of the audit, they also reviewed the capacity assessments.

The Mental Health Act administrators offered support and guidance to staff regarding the implementation of the Mental Capacity Act. A number of the administrators had attended additional training in relation to the Mental Capacity Act, which included the interaction between the Mental Health Act and Mental Capacity Act, Deprivation of Liberty Safeguards, restraint and consent to treatment provisions, assessing capacity and general principles, renewal of detentions and leave of absence. The training department had nominated further staff on the training to enhance their knowledge so they could competently provide guidance and advice to staff.

The hospital has not made any Deprivation of Liberty Safeguards applications since the last inspection. All patients were detained under the Mental Health Act.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

We conducted a short observation for inspection on Bridge Hampton ward, a ward for patients who were deaf and may have a learning disability. We sat in the communal lounge and observed interactions between staff and patients. We found staff had good skills in British Sign Language to be able to effectively communicate with patients. Staff were facilitating activities that patients enjoyed, including playing cards, reading the newspaper and watching television with subtitles then discussing the topics on the news.

Across the other nine wards, we observed staff being friendly and warm towards patients. It was evident that staff knew patients well and used humour where this was helpful.

We spoke with 36 patients. Twenty patients reported that regular staff were respectful and polite including knocking on bedroom doors. Nine patients told us that bank and agency staff were not so, with occasions where they had entered their room without knocking. One patient reported that staff were harsh and another that staff were rude. Another patient felt staff treated them differently because they had complained.

Good

Forensic inpatient/secure wards

Staff we spoke with had a clear understanding of patients' needs, including their likes and dislikes, and how best to support them, especially when they were agitated. Staff were able to diffuse situations and offer reassurance.

The involvement of people in the care they receive

When new patients arrived on the wards, staff facilitated a tour of the ward and showed them their bedroom. Patients were informed verbally or by signing of the important information they needed to be aware of. We found there was little evidence of written or pictorial information provided to patients regarding the ward for all wards except Madison. Madison ward had a leaflet to provide information to patients, which included the aim of the ward and some information about the members of the multidisciplinary team. However, this did not include expectations of patients or details of the running of the ward.

There was information on display for patients in all wards except Lower West ward, which just had the activity timetable displayed, and the advocate's details. In other wards, information displayed included the staff that were on shift that day, how to complain, how to contact the CQC, health and wellbeing, safeguarding, plans for the week with activities taking place, the recovery college, advocacy, smoking cessation support, plans for group leave and opportunities to have your say and give feedback via patient recovery outcome meetings.

Accessible pictorial information was on display on Bridge Hampton ward, which was a ward for deaf patients, a number of whom also had a learning disability. Activities planners and information on display was in a deaf friendly format on West Hampton ward, which cared for deaf male patients.

There was evidence of patients being involved in their care planning; we saw examples of documentation written in the first person. At the last inspection, we were concerned, as staff had not created the care plans in a way that was meaningful for patients on Bridge Hampton ward; at this inspection, we found they were accessible with the use of patient's photographs and symbols. On West Hampton ward, they had introduced the recording in British Sign Language of the outcomes and actions from individual patients' care programme approach reviews onto a DVD for individual patients to watch. A care programme approach meeting is where all involved in a patients care discuss progress and future aims and set goals. The meeting focuses on the 'all about me' recovery tool with eight domains, which are communication, identity, my mental health, problems, rights, services, information and healthy living. We viewed one patients' care programme approach DVD with the assistance of an interpreter and then reviewed the paper version and found the aims and goals to be consistent. This is positive progress to enable patient to understand the goals of their care. On Bridge Hampton ward, staff had enlarged a patient's visual care plan as they had a visual impairment; the patient had their plan in their room, which they showed the inspection team.

Advocacy was available for patients with a diverse range of needs and the providers reflected these, including female advocacy, advocacy for people who are deaf or have a hearing impairment and more general mental health advocacy. For patients who were deaf, patients could book timeslots to see the advocate when they next visited, a list of appointment times was on display.

All wards had community meetings. We observed the community meeting on South Hampton ward and found that actions were being progressed and achieved which patients confirmed. Patient recovery outcome meetings had been happening for a while. However, there was no meeting for deaf patients to discuss culturally specific information and feed into the organisation as a whole. However, in February 2017 the ward held their first deaf recovery outcomes meeting. This included six patients, with support from interpreters and staff. Topics discussed included feeding back any issues from ward based community meetings, 'all about me', the deaf recovery tool that was used for meeting the needs of patients, recovery college, and the development of an information booklet for the deaf male services.

Patient newsletters were created on Upper East ward, primarily to communicate to patients the changes in relation to the smoking ban, with three editions created since January 2017.

We did not see any examples of advanced decisions in place for patients.

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

Good

Forensic inpatient/secure wards

Good

Access and discharge

Across the adult wards, average bed occupancy over the last six months was 98%. Patients within the hospital were from across the country due to the speciality of the hospital. Arrangements were made for visitors to come to the hospital; we also saw examples of staff escorting patients to visit family as part of their section 17 leave.

Patients were not moved between wards unless deemed clinically appropriate and funding allowed; for example, the transition from medium to low security or rehabilitation. We also saw examples where patients moved to another ward of the same level of security in their best interests; for example, the mix of patients or targeting of a patient by other patients.

There were no delayed discharges in the adult services from July 2016 to December 2016.

We reviewed 34 care records and found ten included discharge planning. Due to the length of some patients' admissions, discharge may not be realistic currently; however, we found patients' records included clear goals and aims agreed within the care programme approach reviews.

The facilities promote recovery, comfort, dignity and confidentiality

All wards had clinic rooms and communal space for activities to take place. Centrally within the hospital, there was 'central park', which contained pool tables, table tennis and a library. Wards used this room to facilitate activities including quizzes and bingo. There was a gym, which was in use by a patient and their support worker when we viewed the facilities. A physiotherapist assessed all new patients for their suitability for the gym prior to them using the equipment. If there were more complex physical health needs, a GP would be involved in the assessment as to the suitability of the gym.

The recovery college started in January 2017, held in two rooms within the activities department of the hospital. Three patients were accessing the college when we viewed the facilities. Courses advertised in the recovery college prospectus included maths, relax to recover, alpha Christian course, science, English, history, photography, art, cookery and vocational studies.

A workshop was available to patients, offering morning and afternoon sessions. Four patients were accessing the workshop with a support worker when we viewed the facilities. Referrals were made by occupational therapists for patients to access the workshop. The facilitator assessed patients' skills during the activities and tailored the tasks accordingly. Projects had included making jewellery boxes, clocks and garden furniture.

There were two shops available for patients to access and buy items including toiletries, drinks, snacks and confectionery, based on Upper West and East Hampton wards.

Weekly activity planners were in place for each patient. Dependant on the individuals' needs and patient population on the wards, activities included dominoes, pool, use of the sensory room, cooking, gym, local shops, smoking cessation, gardening, art and craft, breakfast group, computers, swimming and sew and natter. Activities of daily living included one to one cooking skills, self-care, laundry and walking group. We viewed pictorial versions of planners at Bridge Hampton, West Hampton, Upper West and Lower West wards. Group activity planners were displayed in each ward to show the variety of activities available on a daily basis; however, we noted on West Hampton ward that the activities were not happening as per the timetable. On Lower West ward, the timetable was out of date as it included smoke breaks and the hospital had been smoke free since the beginning of February 2017.

At the last inspection, we were concerned about the activities available to patients and the appropriateness of them in relation to promoting recovery. Of particular concern was South Hampton ward, as this ward was a rehabilitation ward. At this inspection, we observed the community meeting, good lives group focusing on healthy living and lifestyle and sew and chat group. We reviewed three files on the ward and noted patients were participating in activities of daily living, community leave and group activities on the ward of between 20 and 26 hours in a week. Files showed evidence of needs identified

and short and long term goals, which were rehabilitative in focus. This was positive progress compared to our last inspection and we found that the hospital had met this part of the warning notice.

We viewed the family and children visiting rooms, which were warm, bright, welcoming and furnished to a high standard. Appointments had to be booked in advance to facilitate visitors and ensure the room was available and appropriate staffing levels to facilitate. The social work department facilitated visits involving children.

Patients were allowed their mobile phones on South Hampton, West Hampton and East Hampton ward; in addition patient phones were available on all wards, usually in a side room, allowing patients to make phone calls in private.

All wards had access to outside space, some wards having access to two gardens and the opportunity to care for animals including chickens, ducks and rabbits. However, on Bridge Hampton ward and Lower West ward, staff thought the door to outside should have been open all day. When we checked the door was locked and there was difficulty in locating a key for the door on Bridge Hampton.

Twelve out of 16 patients asked about food said the food was 'ok'. Patients were happy on South Hampton ward that they could make their own meals and did so. Community meeting minutes reported that the food was of high standard on South Hampton ward. Four patients reported the food was not of a high standard and would prefer more healthy options and fewer chips.

Patients were able to make drinks on all wards. On South Hampton ward, patients were freely able to prepare snacks and meals, reflecting the rehabilitative focus of the ward.

Patients were able to personalise their bedrooms and were happy to show us their rooms.

Meeting the needs of all people who use the service

The Equality Act 2010 includes nine protected characteristics of age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity. Services must have regard for, make reasonable adjustments and ensure discrimination does not occur on these grounds.

Individual wards were on one level and could accommodate the needs for patients with mobility difficulties. Where wards were on upper levels of buildings, a lift was available. Occupational therapists were involved for patients who required modifications to their environment to meet their needs including aids and equipment.

Symbols and individual patients' photographs were used within documents on Bridge Hampton ward, a ward caring for some patients who may have a learning disability. British Sign Language symbols, written communication accessible for the deaf community and individual patients' photographs were included in the documents for patients on the four wards supporting deaf patients.

The catering department met dietary requirements, including for faith or health needs. Staff from the catering department had also attended community meetings on occasion to discuss food options.

The hospital employed two full time British Sign Language interpreters who worked flexibly and could work evenings and weekends to meet the needs of the service, if planned in advance. In addition to this provision, the hospital used an agency of regular interpreters to book additional resource when needed.

A multi faith room was available for patients' use. The hospital chaplain had started to facilitate the Alpha course for patients to explore the Christian faith in January 2017. A deaf minister also visited the wards to provide spiritual support for deaf patients. An imam visited the hospital as needed, dependent on the patient population. Staff had made provision for patients to use skype to access services at a local church and enabled a patient to visit a Sikh temple.

If there were patients, whose first language was not English, staff could request for documents to be translated into another language; however, they were not routinely available.

An example was given where, due to their faith a patient participated in ritualistic bathing, which was facilitated by the patient having access to their en suite bathroom rather than the communal bathroom. This was in a female ward, which, at the time limited patients' access to their bedrooms for significant times in the day.

Listening to and learning from concerns and complaints

Good

Forensic inpatient/secure wards

The adults' services had received 119 complaints from February 2016 to January 2017, 10 of which the hospital had upheld. No complaints had been referred to the parliamentary and health services ombudsman.

Patients knew how to complain and felt comfortable raising concerns with staff or discussing at community meetings. We observed a community meeting and found complaints to be resolved locally within the ward. Information was on display in the wards on how to complain including how to contact the CQC.

Ward managers understood the complaints process and advised that if they resolved a complaint locally they would record it within the patient's notes, if the complaint required further investigation they would refer it to the complaints officer to allocate for investigation.

We reviewed three complaints investigations and found the investigations were patient centred and the focus was on learning lessons even where not upheld. There was a complaints officer in post, who oversaw the investigation of complaints and ensured the hospital followed their complaints policy.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

The provider's values remained unchanged from the last inspection.

The values were:

- Helpful – "go the extra mile for service user, customer and team"
- Responsible – "do what you say you will do"
- Respectful – "treat people like you like to be treated yourself"
- Honest – "be open and transparent, act fairly and consistently"
- Empathetic – "be sensitive to others' needs, caring and compassionate."

Staff we spoke with knew what the values of the service were. The hospital used the values during recruitment and shared them during the induction process. Staff we spoke with used the language of the values when discussing care and treatment.

Since the last inspection, there had been a number of changes in the senior management team within the service. The hospital director, who was also the registered manager, had increased the number of clinical managers and they were office based within their relevant service. This had led to an increased presence at ward level and staff throughout reported good support from the senior management team.

Good governance

The governance structure was new at the last inspection. At the last inspection, we found that the governance structures were not always effective in identifying and managing risk and ensuring sustainable improvement.

At this inspection, we found that the governance structure was well embedded with clear lines of accountability and reporting. The hospital had appointed a lead psychologist as well as a clinical quality and compliance manager. Although this was a very recent appointment, staff were positive about this approach and felt more included in the governance process of the hospital.

At the last inspection we found a number of policies were not up to date. Prior to this inspection we requested that the provider submitted their revised policies on seclusion and long term segregation, Mental Capacity Act, Deprivation of Liberty Safeguards, incident reporting and management, safeguarding adults and safeguarding children and young people. We reviewed the policies and found that they were compliant with the Mental Health Act Code of Practice 2015 and the Care Act 2014.

There was a programme of rolling out policies, which staff had to sign to show they had read and understood. Staff were following this system. The governance team had offered practical support by going to the wards and delivering the new policies and removing out of date policies, ward staff saw this as positive.

The system for sharing lessons learned was firmly embedded. Records showed and interviews with staff confirmed that the hospital shared lessons in a number of ways including via team briefs, team meetings, email, and

supervision. The hospital shared learning across all disciplines. A review of three incidents from adults showed that staff had investigated incidents well. The investigator identified local actions and staff carried these out. Where appropriate the hospital shared learning across both adults and child and adolescent services. The hospital supported staff and patients and reflective practice encouraged. Minutes from governance meetings showed staff reported incidents appropriately up to the board and information communicated back to the ward. We saw examples where action plans had led to changes of systems to prevent recurrence and information shared across the hospital. Action plans identified time frames and the person responsible for completion of the action.

The hospital had appointed a new medical director and they were running weekly medical advisory committee meetings. The role of the medical advisory committee is to ensure clinical services, procedures or competent medical practitioners provide interventions. Minutes showed good attendance at these. There was good support from the hospital for doctors to access further training. Doctors were expected to undertake clinical audit and two audits had been started since the recent arrival of the medical director.

The improvements in complaints management, which we saw at the last inspection, had been maintained. Between July 2016 and December 2016, there had been 94 complaints. Seven of these had been resolved within five days and 36 within 20 days. The average time for closing complaints had dropped from 50 days to 30 days. The complaints letter sent were of a very high standard. Staff received training on complaints management at induction. Ward managers had received further training in investigating complaints. Investigations were patient centred and the focus was on learning lessons even where not upheld.

The hospital used a recognised tool for assessing staffing levels and staffed accordingly. Staff on wards told us they were able to book agency staff when needed. Recruitment into nursing vacancies remained a challenge. The hospital were continually recruiting and trying different methods to attract staff. All consultant doctor vacancies had been filled and new staff were currently going through pre-employment checks before starting in post. The hospital had made improvements in how it recruited staff. We reviewed seven recruitment files and saw that the hospital had followed their policies and all pre-employment checks completed. In one case, the person had disclosed a previous conviction. This had been correctly risk assessed and was continuing to be monitored.

Staff were aware of performance indicators and ward managers had access to performance reports. The hospital was using these to improve the quality of care.

At the last inspection, staff were not always receiving appraisals. At this inspection, 91% of nursing staff were receiving appraisals. The figure was 88% for adult services. All doctors were up to date with appraisals. The medical director had taken steps to strengthen processes for doctors to access training and supervision to support them to achieve continuing professional development.

There were improved systems for monitoring training, which the hospital had recently introduced. This allowed ward managers to book and access local figures for training. If a person changed wards, the system would immediately identify any other training that was required.

The risk register included current risks and staff had reviewed these in line with identified timelines. Staff were aware of the risk register and how to submit items to it. The hospital had shared the action plan they had devised following the last inspection with wards. Actions taken were visible for all staff.

Leadership, morale and staff engagement

Staff were involved in a number of different meetings. There were daily meetings between the senior management team where clinical managers fed back about the previous 24 hours. The hospital took minutes of these meetings and shared them with the board. There were also weekly meetings with ward managers for sharing information. Staff reported feeling very supported by their managers, particularly the clinical service managers.

Staff gave us examples where they had made suggestions and been listened to. For example, staff had identified that Upper West, a medium secure unit for hearing and hearing impaired women, had a high level of acuity. Senior managers had made a case and the provider had agreed that the ward could recruit two extra team leaders to help provide leadership on shifts, and a full time administrator

to release staff to care. When there had been a sharp rise in complaints at the end of the year, the hospital had provided extra support to ensure that complaints were responded to as quickly as possible.

Sickness rates for the period February 2016 to January 2017 ranged from 1.6% on East Hampton to 6% on Upper West. The average across the hospital was 3.6% and the adult service was performing at the hospital average of 3.6%. Staff turnover from February 2016 to January 2017 ranged from 0.5% on South Hampton to 5.7% on Lower West, with a hospital average of 3.3%. The adult service was performing slightly worse with a turnover of 3.7%.

There were clear whistleblowing processes and staff knew how to raise concerns and felt able to do so. An example was provided where the organisation had undertaken a thorough investigation in response to concerns raised.

There had been no bullying and harassment cases from February 2016 to January 2017.

Mostly staff felt empowered and supported to do their job. Staff in acting ward manager roles described feeling very supported by the hospital and happy for the opportunity to develop their careers. The hospital provided ward managers with leadership training. Staff told us they had good support from colleagues as well as managers.

All the staff we spoke with described saying sorry if something went wrong. Staff knew being open and transparent were part of their values and provided examples of where they had apologised. Staff received training in duty of candour at induction. There were effective systems in place for identifying whether an incident reached the duty of candour threshold and monitoring the actions taken. Since our last inspection, there had been no incidents within the adult services that reached the duty of candour threshold.

Commitment to quality improvement and innovation

Medium and low secure services were part of the Royal College of Psychiatrist quality network for forensic mental health services. The hospital had recently been assessed and the report was going through assurance processes before being finalised.

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Safe and clean environment

All wards were clean, tidy and in a good state of repair. The furniture was of a good standard and patients' artwork was displayed on the walls.

On all wards, there were blind spots. Staff mitigated these by the use of observations, risk assessments and mirrors. Ligature points were risk assessed on an annual basis by the ward manager. A ligature point is anything that patients could use to harm themselves by strangulation. The annual risk assessments identified any ligature points and actions for staff to reduce the associated risks. Staff reduced the risks by observations and being present in areas with higher risk, individual risk assessments and care plans. Staff mitigated risks present on their ward.

All wards except Buttercup were mixed gender. The wards all complied with guidance on same sex accommodation. This included separate sleeping areas for males and females, all patients having en-suite bedrooms, and there was a separate female lounge.

Each ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs. Staff checked the emergency drugs and resuscitation equipment regularly. However, at Wizard House we found that one of the emergency drugs had been out of date since November 2016. Staff ordered a replacement immediately when we highlighted this. Staff checked fridge temperatures daily and records were up to date. In each of the clinic rooms there was equipment such as scales, blood pressure machines and, where required, an examination couch.

During our last inspection, we raised concerns about the seclusion facilities on the psychiatric intensive care units. We found that the only functioning seclusion room at that time was on Primrose ward, which was a female only environment. This meant that male patients would have to be brought onto that ward if they needed seclusion. There were also concerns about the distance the distressed patient would have to travel to get to that seclusion room. The policy stated that no patient should be walked up or down stairs to get to a seclusion room; however, as there was only one seclusion room in use this policy was not being adhered to.

During this inspection, we found that there were two seclusion rooms in use for the three wards. One was situated on the ground floor and one on the first floor. This meant patients were not usually going to a different floor for a seclusion room. However, there may be occasions when the seclusion room was in use and a patient needed seclusion. A new protocol was developed in December 2016 for those instances. This was developed in conjunction with the management of actual or potential aggression lead and reducing restrictive practice lead around the safe movement of patients. This stipulated the process staff must follow if a patient was being moved to seclusion on another floor, including how many members of staff were needed, use of a two-way radio to maintain communication at all times, how to move between locked doors and the use of the lift rather than the stairs. Staff we spoke with had a good understanding of the new protocol. A high dependency area was in use on Wizard House, for

de-escalation, de stimulation and seclusion there was no issues found with this at our past inspections. The seclusion rooms met with requirements in the code of practice, this included clear observation, two-way communication, toilet facilities and a clock.

The environment was regularly cleaned and cleaning records were up to date. There were cleaning stickers on equipment to show when they were last cleaned. Staff adhered to infection control procedures; for example, washing hands at appropriate times such as before and after giving medication.

Staff wore alarms that could be pressed for assistance or pulled to call for help in an emergency. There were nurse call buttons in patient bedrooms and in communal areas. Staff were allocated to respond if an alarm was raised.

Safe staffing

During our last inspection, we raised concerns regarding the fact that ward managers were tasked with managing two wards simultaneously. This arrangement did not meet national standards as set out in the quality network for inpatient child and adolescent services by the Royal College of Psychiatrists. The set standard is one full time ward manager to every 12 patients. During this inspection we found that this had changed, there was a ward manager for each of the wards. Ward managers told us this had been a positive change that meant they were able to fully focus on one ward and therefore pay more attention to the staffing and the patients.

At the time of our inspection the staffing establishment for each ward was as follow:

Establishment levels: qualified nurses (Whole Time Equivalent)

- Wizard 6.9
- Mulberry 6.9
- Buttercup 6.9
- Primrose 6.9

Establishment levels: nursing assistants (Whole Time Equivalent)

- Wizard 25.2
- Mulberry 29.8
- Buttercup 25.2
- Primrose 34.5

At the time of our inspection vacancies for each of the wards were as follows:

Number of vacancies: qualified nurses (Whole Time Equivalent)

- Wizard 4
- Mulberry 1
- Buttercup 2
- Primrose 2

Number of vacancies: nursing assistants (Whole Time Equivalent)

- Wizard 1
- Mulberry 2
- Buttercup 2
- Primrose 6

The hospital used bank and agency staff when they had vacant shifts. Where possible shifts were filled with permanent staff; when this was not possible, agency staff were used. The total number of shifts covered by bank and agency between November 2016 and January 2017 were as follows:

The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies

- Wizard 278
- Mulberry 293
- Buttercup 276
- Primrose 375

In the same period the number of shifts that were not filled were as follows:

- Wizard 0
- Mulberry 3
- Buttercup 1
- Primrose 3

The staff sickness and turnover rate from February 2016 to January 2017 were as follows:

Sickness

- Wizard 4.2%
- Mulberry 3.6%
- Buttercup 4.9%
- Primrose 1.8%

Turnover

- Wizard 3.1%

- Mulberry 1.3%
- Buttercup 2.8%
- Primrose 2.6%

Managers used a tool to estimate the number of staff needed depending on the number of patients on the ward. Ward managers were clear that they were able to increase the numbers of staff on duty if there was a need. On wards where there were higher vacancy levels, agency staff had been block booked for three months at a time in order to ensure that staff who were familiar with the ward and patients were on shift. Every ward had two qualified nurses on shift during the day and one at night. During our inspection, we saw a qualified nurse in the communal areas of the ward at all times.

At our last inspection, there had been a new policy implemented, staff carried out one to one sessions on a named nurse basis. Patients had one to one time planned in with the nurse that was allocated to their care. In between these times, all other staff were available for patients to talk to if they so wished. Staffing was sufficient to be able to take patients out on leave from the wards. We requested the log of episodes of cancelled leave between November 2016 and January 2017. There were no episodes of leave cancelled due to staffing issues. There were sufficient staff to be able to carry out physical interventions if required. Staff wore alarms and when these were activated staff from other wards immediately responded to help.

Medical cover for each ward was provided by a consultant psychiatrist. Junior doctors were based on each ward during working hours. Outside of these hours, there was an on call rota and doctors would attend the ward when required.

There had been a review of the mandatory training at the hospital since the last inspection. Training that was mandatory was; medicines, prescriptions and administration, side effects, basic life support, hands off, reducing restrictive practice, immediate life support, information governance, management of actual or potential aggression, the Mental Health Act, a security refresher and a specialist programme for child and adolescent services. There was a new tracker tool in place, which allowed managers to see how their own ward was complying with mandatory training at any time. The compliance with mandatory training across the child and adolescent wards was low at 60%. A number of courses were newly introduced and we were able to see where staff had been booked on these this would improve the compliance rate. There was 100% attendance at the hospital induction. This included complaints, duty of candour, equality and diversity, fire, fluids and nutrition, information governance, mental health awareness including the Mental Capacity Act, safeguarding adults and children level one and security.

Assessing and managing risk to patients and staff

We looked at information provided by the hospital in relation to the use of seclusion and restraint. Seclusion was used in the six months from August 2016 to the end of January 2017, on Wizard House six times, on Mulberry 21 times, on Buttercup 14 times and on Primrose 47 times.

All of the wards had used restraint in the six months from August 2016 to end of January 2017. The number of restraints were as follows: Wizard House 102, Mulberry 311, Buttercup 245 and on Primrose 627 times. We were able to review the data packs each ward received on a monthly basis. This gave information of why restraint had been used, time of day it was used and the day of the week it was used. We could see that over the months of October and November 2016 there had been a large spike in restraint used on Primrose Ward. Primrose Ward was an all-female ward that was used as a precursor to secure services. During the months of October and November 2016, there was a cluster of patients awaiting beds in medium and low secure services; this led to a rise in restraint due to incidents of harm to staff and other patients. Three young people were presenting aggressive behaviours targeting staff and the majority of the restraints were for these young people. Ward Managers discussed this daily at a morning meeting. Managers explained ways in which they were trying to reduce incidents of restraint on Primrose ward. This included following up referrals to medium secure services, active participation in 'safe wards' to reduce incidents and significant emphasis on the completion of positive behavioural support plans focusing on the primary strategies to support the patient before a crisis. The numbers of restraint reduced in January from 122 to 96. During this same period, prone restraint had been used on each of the wards. Wizard House had used it twice, Primrose ten times, Mulberry five and Buttercup three times. Prone restraint is when patients are placed faced down whilst being held by staff. National guidance states that prone restraint should be avoided where possible. This

is because there are dangers with prolonged prone restraint such as patients being at higher risk of respiratory collapse. However, staff were clear that when prone restraint was used this was for the shortest time possible and the patients were rolled over at the earliest opportunity. Ward managers recorded all incidents of restraint on the electronic recording system, they also received a restrictive interventions data packs on a monthly basis. This included the use of restraint, seclusion and prone restraint. Ward managers would meet at a monthly governance meeting where they would explain reasons for increases in any of these areas and ways in which they were trying to reduce any areas of restrictive practice.

During the inspection, we looked at 22 care records in total. Each record had an up to date risk assessment. The hospital used the Salford tool for the assessment of risk. All risk assessments we saw were completed to a high standard and included management plans for each patient that were individualised included the patients views and were signed by the patient. If the patient was too unwell to take part in the process, this was clearly documented in their records and further attempts were made to engage the patient at regular intervals.

There was a clear culture of least restrictive practice across all of the wards. We found little evidence of any blanket restrictions. The only exception to this was that patients were not allowed their own mobile phones on the wards. Patients were instead given a ward mobile phone, which had the telephone numbers of their family and close friends stored in them. On Wizard House, some of the patients had created a presentation that they delivered to senior staff, which highlighted what they thought the benefits and risks of patients having their own mobile phones would be. Following this, the hospital was reviewing this blanket restriction with a view to patients being able to have access to their own mobile phones on a more individualised, risk assessed basis. However, at the time of our inspection this restriction remained.

Patients on Buttercup, Mulberry and Primrose wards were always detained. However, on Wizard House, this was not the case and informal patients' rights were clearly displayed and explained to patients on admission and during one to one sessions.

There was an observations policy for staff to follow. The service used zonal observations and the policy described the different levels of observations. This ranged from staff being on constant observations to patients being checked every three to seven minutes. Staff were clear on how the observations worked and we found that this was being adhered to during our inspection. There was a search policy, which clearly defined how, and when to search a patient. This included searches prior to and on return from unescorted leave. There were no patients being searched at the time of our inspection but staff were clear on what their responsibilities were when searches occurred and how this was carried out and documented. Random searches could be carried out of patients' bedrooms if there was a rise in incidents relating to banned items. If patients were subject to searches this was documented in a search plan and this was risk assessed on an individual basis.

At our last inspection, we raised concerns regarding the monitoring of patients post rapid tranquillisation. We found that the hospital monitoring form instructed nursing staff to complete physical observations where possible following rapid tranquillisation for at least 90 minutes. Ninety minutes included if a patient was asleep at the point of observation. However, we reviewed 12 rapid tranquillisation physical health monitoring forms and found that nursing staff had not continued to monitor three individual patients as per protocol when they were asleep within the 90-minute period. This put patients at risk. At this inspection, we found this issue had been resolved. The hospital had recently reviewed its policy for monitoring of patients following rapid tranquillisation. This meant that oral and when required medication was monitored post dose in the same way as rapid tranquillisation given via intra muscular injection as recommended by NICE guideline [NG10]: Violence and aggression: short-term management in mental health, health and community settings May 2015. We reviewed records for monitoring of patients following this type of medication and found them all to be completed correctly. Staff were aware of the changes and ward managers carried out a daily audit of the monitoring forms so that any errors were picked up immediately.

We reviewed the use of seclusion and found that all documentation was completed correctly and reviews took place within the correct timescales. We saw evidence that seclusion was used for the least time possible and was terminated at the earliest opportunity.

Good

Child and adolescent mental health wards

The hospital provided training to all staff on safeguarding children and vulnerable adults. With 100% attendance at safeguarding level three which was included in the induction. Training attendance in safeguarding children level three was 91% across the child and adolescent wards. There was some training planned for April 2017 where the multi-agency safeguarding hub would come in to deliver this to staff. There were safeguarding champions in each area that staff could go to for advice around potential safeguarding concerns. The safeguarding lead had completed training in level four safeguarding children and adolescents. All safeguarding incidents were reported via the electronic incident reporting system. There was a weekly meeting of the safeguarding leads where they discussed any ongoing safeguarding incidents and reviewed them. The staff all described good working relationships with the multi-agency safeguarding hub and described them as being quick to respond when they made a referral.

The hospital had a contract with an external pharmacy. The pharmacist visited the wards on a weekly basis and carried out audits around medication. This included audits around prescribing of medication, administration errors and storage of medication. These audits were fed back to ward managers and discussed at weekly governance meetings.

Visiting facilities were available for all wards. These were situated off the main ward area so that visits could take place in a quiet setting. Risk assessments were carried out prior to visits and staff were present at visits if necessary.

Track record on safety

There were 21 serious incidents in the child and adolescent service between January 2016 and February 2017.

A review of four incidents from the child and adolescent mental health service showed that incidents were investigated well. Local actions were identified and carried out and where appropriate learning shared across both adults and child and adolescent service. Staff and patients were supported and reflective practice encouraged.

We saw improvements in safety as a result of learning from serious incidents. One example of this was when a patient had stopped the water draining from their shower in an attempt to self-harm. As a result of this, a time response was added to the showers where they could be set to turn off after a specific time if the risks for that patient were deemed high.

Reporting incidents and learning from when things go wrong

The hospital used an electronic incident reporting system. All staff had access to this and were able to enter an incident onto the system. Senior staff (ward managers and senior nurses) had access to review these incidents. Staff were able to give us examples of what would need to be recorded on this system and how they would do this. Staff could use the system to access feedback from an incident they had entered. However, ward managers ensured they gave feedback from incidents via staff supervision and this was an agenda item on both supervision templates and for team meetings.

At our last inspection, we found that although learning from incidents took place within the child and adolescent mental health service, these were not routinely shared across the child and adult services. During this inspection, we found that this was now happening and that staff in the child and adolescent mental health wards were aware of serious incidents that had occurred on the adult wards. There was also a bulletin where lessons learnt were shared across all services and staff were able to give us examples of these. The bulletin was displayed in the ward offices for all staff to read.

Debriefs occurred post incidents and we were able to see evidence of this in records. Staff told us this was helpful as there were a high level of incidents due to the nature of the wards. Staff told us they felt they could talk openly about how they felt following an incident and that the psychologists for the teams were involved in debriefs. Debriefs also took place for patients and they told us that they found this time useful to look back on an incident and understand why it happened and how they felt.

Duty of Candour

Duty of candour is a legal responsibility on hospitals to apologise and inform patients if there have been serious mistakes in their care and treatment that led to significant harm. This allows patients to receive a truthful account of failings in their care as well as a written apology.

All staff we spoke with had an understanding of duty of candour at a level appropriate to their role. Staff were able to give examples of what would trigger a response under duty of candour and how this would be dealt with. There had been one incident that triggered a response under

Good

Child and adolescent mental health wards

duty of candour regarding documentation. We saw evidence of the appropriate action being taken and learning from this incident. Following this, changes were made to ensure this type of incident did not occur again.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed records for 22 patients during our inspection. We found that all of these contained a comprehensive, holistic and timely assessment completed on admission. Staff and patients completed assessments together and reviewed them on an ongoing basis, using the "my shared pathway" care plan model. This model encourages a recovery and outcome based approach to planning care, setting out agreed timescales for goals to be achieved. The patient and the member of staff agreed these together. Care plans were inclusive of the patient's strengths and weaknesses and were in 14 cases written partly or in full by the patient. Where patients did not want to engage we saw evidence of ongoing attempts to help that person engage in a way that was meaningful to them.

All records contained a physical health review, which was completed on admission and reviewed throughout admission during weekly reviews. There was a physical health team at the hospital and they were responsible for ensuring that patients' physical health checks were up to date and completed on time.

Each patient's educational needs were taken into account on admission. There was a newly appointed pastoral lead who was responsible for engaging those patients who may have been out of the education system for some time or whose mental health needs meant they found it difficult to engage. The pastoral lead would spend one to one time with those patients encouraging them to take small steps to attend perhaps just one lesson a day to begin with. They would also try to engage with the patient's home schools to ensure that all young people were working in line with the curriculum so there would be an easier transition back into mainstream school once discharged. If patients were too unwell to attend any of the education sessions, then the pastoral lead and other staff would try to engage those patients in other activities that they enjoyed such as music and crafts. However, as most of the patients were not from the local area it was difficult for them to engage in education once they were past high school age. This meant that some young people aged 16 to18 years were not engaging in education that was appropriate for their age. Where possible the hospital would try to engage with local colleges but this was difficult due to the short lengths of stay once patients were well enough to leave the psychiatric intensive care units.

At our last inspection, we found that although all patients had a positive behavioural support plan in place, these were mostly reactive in nature. This meant they supported patients once they were distressed to calm down but did not give patients methods to prevent them from getting to that distressed stage. During this inspection, we found practice in this area was much improved. All patients had positive behavioural support plans in place, which gave them the tools to manage their emotions on a day-to-day basis, as well as in a crisis. Patients were clearly involved in developing these plans with staff and psychologists took the lead on this. Patients we spoke to told us they had developed skills to manage their own difficulties and found these useful.

Patients used the "my say" form prior to multi-disciplinary reviews. This was a way of patients taking the lead in their own reviews and being able to write down their thoughts, feelings and questions prior to entering the review. We saw evidence of responses from staff documented on the forms. Patients told us they found this helpful and meant they did not forget things they wanted to ask during the meeting. Staff told us that if patients did not want to take the lead in their review then a member of staff or an advocate could complete the form prior to the meeting with the patient and then feed this back to the multi-disciplinary team on behalf of the client.

All records were stored securely in a locked cabinet in a locked room. Some of the records were stored on an electronic system and this was accessible using a password. All staff reported that they found no issues with using the two systems and found them easy to navigate.

Best practice in treatment and care

We checked 24 prescription cards during our inspection and found the prescribing practices to be of a good

standard. Antipsychotic medications prescribed were within the children's and young people's British National Formulary limits. The staff followed guidance provided by National Institute for Health and Care Excellence guidance for child and adolescent mental health services; for example, 'psychosis and schizophrenia in children and young people: recognition and management CG155', 'depression in children and young people: identification and management CG28' and 'self-harm in over 8's: short-term management and prevention of reoccurrence CG16'. Compliance with guidance was monitored by the governance meetings and was discussed in staff supervision.

Since our last inspection, the psychology input across the service was improved. There was a dedicated psychologist for each of the child and adolescent wards as well as two assistant psychologists on Buttercup to support the head of psychology. A new post for an art therapist had recently been approved and the job description and person specification were being developed by the team. Each ward had one psychology group per week. The group sessions covered the following:

- Mindfulness
- Coping with emotions
- Preparing for formal therapy
- Reducing self harm
- Control group

The groups used a mixture of cognitive behavioural therapy and dialectical behavioural therapy. This type of psychological therapy is recommended by National Institute for Health and Care Excellence in guidance CG133; self-harm in over 8s and long-term-management. In addition to the group sessions, each patient was offered a one to one direct appointment per week as a minimum. This varied depending on need if more sessions were required then this was offered. The one to one sessions were individualised depending on the area of focus. Therapeutic interventions on offer were:

- Assessments of mental illness, autistic spectrum disorder and emerging personality disorder
- Attachment
- Trauma
- Cognitive behavioural therapy

There was a well-established physical health care team at the hospital made up of senior nurses. They were able to provide a range of physical healthcare interventions for patients. This included a weekly physical health clinic where a GP attended to give treatment and advice to patients. The physical health team were able to monitor ongoing physical health need for patients and refer to specialists if required. For example, we saw referrals to dietician and podiatry services in patient records. We saw evidence of ongoing physical health monitoring when reviewing patient records.

Staff used rating scales in order to monitor and record outcomes for patients. They used the health of the nation outcome scale for children and adolescents and the children's global assessment scale. These were completed on admission and revisited during weekly reviews and on discharge. On Wizard House, staff had recently introduced a new process following a ward improvement meeting. This meant that at each patients second review meeting (after their signs and symptoms were discussed at the first) each professional involved in their care would need to bring one completed rating scale to the meeting.

At our last inspection, many audits were carried out by the senior leadership team. During this inspection we found that a new governance lead had been employed who had ensured that ward managers and ward staff were empowered to carry out their own audits with oversight at governance meetings. This meant that staff understood the use of audit to improve care and treatment for patients. Staff told us that by completing the audits themselves they could see why they were being done and understand the importance of them. There were audits on patient records, Mental Health Act paperwork and rapid tranquillisation amongst others.

Skilled staff to deliver care

There was a range of qualified and experienced staff to ensure that the needs of the patients were met. This included nurses, doctors, support staff, occupational therapists, psychologists, social workers, teachers, administration staff, domestic staff and activity facilitators. At our last inspection, we found that there was no female psychologist, which made it difficult for patients on the female wards to engage in psychological therapies. During this inspection, we found that the service had employed several female psychologists to engage with patients who preferred to work with a female.

Good

Child and adolescent mental health wards

The compliance rate with the appraisal process across the four wards was 96%. This included 100% compliance on both Wizard House and Mulberry ward with the other two wards being over 95%. At our last inspection, we found that compliance with appraisal was not only variable but that staff had identified areas for training or improvement and these had not been followed up on. This time we found that staff found the appraisal process had much improved. They were able to show us how needs identified during the appraisal process were followed up by the ward manager. Staff told us that this not only improved their practice but also made them feel that the senior team listened to them and acted upon their needs.

We reviewed supervision records on all of the wards. We found that supervision, both clinical and managerial was happening in line with the policy (monthly) and was being recorded on the correct paperwork. The agenda included training, workload/priorities and organisational issues. There was a system where supervision records were scanned onto the computer to keep an accurate record of when supervision occurred and with whom. Staff also received a copy to keep for their own file. There was also reflective supervision session weekly, led by the psychology team on each ward. This allowed staff to discuss any issues with patient care or within the staff team in an open and supportive forum. Staff reported they found this helpful especially when dealing with a difficult or emotive subject.

During our last inspection we found that compliance levels with specialist training for the role was low. This consisted of training in personality disorders and eating disorders. However, during this inspection we found that a specialist course that was taught over five days had been developed specifically for child and adolescent service staff. This was a new course that had been rolled out from early 2017. Although compliance rates were low this was a new course that took staff away from the ward for five days at a time so it was important for managers to do this gradually so as not to affect staffing levels on the wards. We were able to see that more staff were booked on in small groups throughout the year. Compliance rates at the time of our inspection were as follows:

Buttercup 13%

Mulberry 20%

Primrose 9%

Wizard House 13%

Ward managers were clear they were able to address poor staff performance. We saw evidence of managers appropriately referring staff to occupational health and reviews being carried out by ward managers due to high levels of sickness. Ward managers would initially manage poor performance at ward level via informal action plans and increased supervision. Human resources staff supported ward managers when this process became formal, but they could ask for support and advice at any time.

Multidisciplinary and inter-agency team work

There were weekly multidisciplinary team meetings; this is where the professional team looking after a patient meet to discuss the patients care and treatment. Patients were encouraged to lead during their own meetings and used the “my say” form to prepare for the meeting. The consultant psychiatrist, junior doctor, named nurse, psychologist, occupational therapist and the patient and their families attended these meetings.

There were two handovers each day at change of shift, attended by all staff on duty. During handover, staff discussed each patient in turn including current or new risks and an overview of the last 24 hours, any leave the patient had and how it went and if there had been any incidents.

There were effective working relationships with outside organisations. This included the home teams of the patients who were not from the local area. Records showed that staff kept in touch with care coordinators and updated them on the progression of their patients. Care coordinators were invited to attend review meetings. As most of the patients at Cygnet Bury lived significant distances from the hospital this was not possible every time. Therefore, the hospital had installed video link and conference call facilities to ensure they were kept involved. There were also good relationships with the local safeguarding team who were due to provide training to the staff in April 2017. There was a weekly meeting held where the ward managers would discuss open safeguarding cases with the multi-agency safeguarding hub and gain feedback on what was happening with the open cases. Staff reported the team were responsive to their needs and always let them know the outcome of investigations. The GP that

attended the wards for physical health clinics was available to staff for advice outside of these hours. Feedback from staff was that they had a good working relationship and could ring to ask questions or take advice.

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

During our last inspection, we found some concerns in relation to the Mental Health Act. We found that staff had not received training on the Mental Health Act code of practice published in 2015. Ward managers were unsure if the training provided by the hospital incorporated the new code of practice and staff knowledge of it was variable. We had some concerns around consent to treatment where an example was found on Mulberry Ward where one patient had a T2 (this form is completed when a detained patient has the capacity to consent to treatment and has done so) and a section 62 treatment provision (certificate of emergency treatment – for patients deemed to not have the capacity to consent to treatment they need urgently) running concurrently. There were also some concerns around the length of time it took a second opinion doctor to be requested after medication was authorised under a section 62 emergency treatment. However, during this inspection we found that this was much improved.

The hospital provided Mental Health Act training to all staff at induction with 100% attendance. The senior Mental Health Act administrator had re-written the induction and refresher training for ward-based staff. Both had a written test to assess learning. Since October 2016 the Mental Health Act team had been running two refresher training sessions each week to enable as many staff as possible to attend the refresher training. Training attendance for the refresher course across the child and adolescent wards was:

Buttercup 4%

Mulberry 16%

Primrose 23%

Wizard 21%

A reference guide to the Mental Health Act had also been developed and this was given out as part of the induction and refresher training. This included information on the Human Rights Act, Code of Practice, Mental Capacity Act and Deprivation of Liberty Safeguards. Training included recent case law updates. Staff we spoke with had a very good understanding of the Mental Health Act and the code of practice.

A Mental Health Act administration team was in charge of ensuring all paperwork was correctly filled out and updated. Staff were aware of who the team were and told us they could ring or email them for advice on anything to do with the Mental Health Act. The team kept track of when things were due such as renewals, tribunals and rights and would emailed staff in plenty of time.

We examined 22 records during the inspection and found the Mental Health Act paperwork to be of a high standard. Patients who were detained had their rights read to them at the correct intervals and this was recorded in their notes and diarised for when it was next due. Patients we spoke with were aware of their rights and had information leaflets they could refer to. We found that capacity and consent to treatment requirements were followed and that patients had either consented to treatment or it had been authorised by a second opinion appointed doctor and the appropriate forms (T2 or T3) were attached to the patient's medication charts.

There was a quarterly audit of Mental Health Act paperwork; this was carried out by the Mental Health Act administration team. All wards were visited and the Mental Health Act detention paperwork checked. Any breaches found were sent to the relevant administrator who was then given a time frame within which this needed to be corrected. The legal section of patient files was audited files which included detention documents, transfer orders, capacity assessments, consent, section 132 rights, section 17 leave, tribunals, manager's decisions and solicitors correspondence. The mental health administration team were responsible for this section of patients file. Legal documents were laminated and kept on the wards. The pharmacist checked the T2 and T3 forms were in alignment with the patient's medication charts. We reviewed the audits during our inspection and found them to have been completed on time and actions followed up on. With regard to the concerns around section 62 and the timeliness of requesting a second opinion doctor, this was also audited. A procedure had been introduced so that if the responsible clinician issued a section 62, they had to ring or email the Mental Health Act office straight away. The responsible clinician was then expected to complete the second

opinion doctor request form and e-mail it to the Mental Health Act administrator who tracked it. Responsible clinicians were sent a reminder four weeks before the consent to treatment was due, which prevented waiting until the last minute to request a second opinion doctor.

There was an independent mental health advocacy service for all patients. There was one service specifically for females to access, this was a well-established and well used provision. At our last inspection, it was reported that the service for male patients was not as responsive to the needs of the patients. This service had now changed and the new advocacy service received good feedback from both patients and staff. Patients told us that they felt the advocacy service was helpful and that they often attended meetings with them to ensure their views were heard. There were posters for the advocacy service on all of the wards and patients knew the names of the advocates that regularly attended the ward.

Good practice in applying the Mental Capacity Act

At our last inspection, we found that there were significant issues in relation to the Mental Capacity Act across the child and adolescent service. We found the Mental Capacity Act policy did not comply with the Mental Health Act 1983 Code of Practice and the hospital did not have a policy in relation to Deprivation of Liberty Safeguards. We found one example of a 17-year-old patient who had been subject to a Deprivation of Liberty Safeguards application. However, deprivation of liberty safeguard emergency and standard authorisations only apply to patients over the age of 18. In cases of young people under 18 who cannot consent to being admitted informally and do not meet the criteria for detention under the Mental Health Act, it would fall to the court of protection to make a decision on whether the patient could be admitted under a deprivation of liberty safeguard. At the time of our inspection, the hospital had not applied to the court of protection for this. Therefore, that person had been detained without the appropriate safeguards for two weeks. We issued a warning notice in relation to this. At this inspection, we found this to be improved.

Prior to this inspection, we requested that the provider submitted their revised policies on Mental Capacity Act and Deprivation of Liberty Safeguards. We reviewed the policies and found that it was compliant with the Mental Health Act Code of Practice, 2015 and the Care Act 2014. Specific contracts had been drawn up by the provider's lawyers about what could actually be consented to in the child and adolescent service. These contracts were treated as part of the legal authority for admission and treatment. All senior staff had been trained on the use of the new forms.

The Mental Capacity Act does not apply to children under the age of 16. In these cases the Gillick competence test is used in British medical law to determine if the person under 16 is able to make a decision to consent to their own medical treatment without the need for parental consent or knowledge. This allows staff to determine if some children have the maturity to make these decisions for themselves. Staff we interviewed had a very good understanding of all these frameworks and how to apply them to the patients under their care. We reviewed 22 records during our inspection and found that capacity to consent was well documented and regularly reviewed. Where capacity was assessed this was done on a decision-specific basis with regards to significant decisions, and patients were given every possible assistance to make a specific decision for themselves before they are assumed to lack the mental capacity to make it.

Since our last inspection there had been a new policy put in place and different forms within those policies to use dependent on the child's age to assess capacity. There had been training on the Mental Capacity Act, Deprivation of Liberty Safeguards and Gillick competence, this was initially for medical staff, Mental Health Act staff and managers but was being rolled out to all staff. At the time of our inspection compliance rates for this training was as follows:

Buttercup 20%

Mulberry 20%

Primrose 25%

Wizard House 75%

The hospital had also arranged some extra Mental Health Act training with a local law firm. This was an intensive two-day training course due to take place in May 2017. Two key areas of this training were the interface between the Mental Health Act and Mental Capacity Act. It also included Deprivation of Liberty Safeguards, restraint, consent to treatment, assessing capacity, renewal of detentions and leave of absence.

Good

Child and adolescent mental health wards

Information leaflets were available for staff and patients, which explained the five statutory principles of the Mental Capacity Act.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

During our inspection, we observed staff in the communal areas interacting with patients in a kind, caring and compassionate way. We observed staff ensuring they acknowledged patients requests and explained what they would do and when. Staff were able to tell us about the patients they were looking after. They had a good understanding of their care needs and were able to tell us about their individual care plans and how to best care for each individual patient.

Patients told us that the staff treated them with kindness and spent one to one time with them when they needed extra support. They told us that they felt safe in the hospital and that staff understood their needs. Patients and their carers told us that they felt involved in their care and that their contributions were listened to and acted upon.

The involvement of people in the care they receive

There was a strong culture of patient involvement on all wards. On admission, patients received a pack with information about the ward they were admitted to. During our inspection, patients showed us around the wards and were able to tell us what different rooms were used for and show us their contributions to art and craftwork around the wards. There was artwork on the walls designed by the patients with the staff and during our inspection at Wizard House; the patients were painting the walls with a new design.

The service used the "my shared pathway" model of care planning and all patients who agreed were involved in their own care planning. When this was not the case there was a clear reason given in the patient records and this was revisited regularly to try and encourage the patient to engage in their care plan. Patients told us that they had a copy of their care plans if they wanted them and that they understood what was in them. Patients were actively involved in the review process and were encouraged to take the lead in these meetings rather than the professionals. For those that needed extra support there were independent agencies who would attend and assist the patient to put their views across.

All patients had access to an independent advocate who visited the ward at a minimum of twice weekly. All patients told us that they knew who the advocate for their ward was and when they visited. They also told us that they could ask the advocate to attend meetings with them for support and that their contact details were up on the walls around the wards.

Relatives and carers were also involved in the patients care and were encouraged to attend the ward for meetings regarding the patient to give their views. Staff told us that relatives and carers were involved in the patients' care. If consent was given, then this was documented clearly in the patient records. Staff would speak to relatives on the phone regularly, especially for people that were far away from home.

Each ward had a morning meeting, where patients would come together and discuss their plans for the day. This also included any plans for leave so that times could be agreed by staff and patients. Patients chaired this meeting. In the evening there were reflective meetings where patients came together again and discussed how their day had gone, again this meeting was patient led. There was a new empowerment meeting where staff gained feedback from patients on their experiences on the ward in order to inform future practice. Each week there was a community meeting where all staff would attend, including the domestic staff and chef. These minutes of the meetings were displayed on the ward and responses provided by the most suitable person dependent on the request. During our inspection we reviewed minutes of these meetings and saw examples of when there had been changes following on from the meetings. For example, staff ordered large outdoor games and a pool table. Patients on Wizard House were involved in interviewing of staff and there were three patients on the ward during our inspection who had been involved in the process.

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

(for example, to feedback?)

Good

Child and adolescent mental health wards

Good

Access and discharge

Average bed occupancy over the last 6 months was 96%. There were beds available for people living in the local area. However, as there was a lack of psychiatric intensive care beds for patients nationally, there were often patients who lived long distances from the hospital in Cygnet Bury. However, leave beds were never used due to the commissioning arrangements for beds. Therefore, if patients went on overnight leave there was always a bed for them on their return.

If patients were moved between wards during their admission this was based on the needs of the patient. For example, patients often moved from one of the psychiatric intensive care units to Wizard House as a step down prior to discharge. Primrose ward was a female only environment so patients could be moved there if they needed single sex accommodation for any reason.

Discharges were always planned well in advance, especially for patients who lived a long distance away as this then involved coordinating transport and escorts if needed. This always happened at an appropriate time of day. There was a referrals, admissions and discharges meeting once per week where professionals discussed patient flow. This meant that all managers had an oversight of what was happening with beds across the service and that they could address any unnecessary delays.

Three of the four wards were psychiatric intensive care units. If a patient on Wizard House deteriorated in their mental health then they could be transferred over to one of the three intensive care units for a period of time.

There were six delayed discharges in the child and adolescent service from July 2016 to December 2016. All of these related to awaiting beds in specialist units.

The facilities promote recovery, comfort, dignity and confidentiality

During our last inspection, we raised concerns regarding the lack of clinic room space across the psychiatric intensive care units. At that time there was only one examination room for all four psychiatric intensive care units and clinic rooms were either too small or shared. This meant that there was a lack of space to carry out physical examinations in a private and dignified way. During this inspection, we found that the service had made changes in this area. There was a clinic room for each ward. Although not all of them had an examination couch patients all had individual bedrooms where examinations would ordinarily be carried out and patients we spoke with told us they were happy with this, as they felt comfortable in their bedroom area.

All of the wards had a range of rooms and equipment to support treatment and care. Rooms on the wards included activity rooms, quiet lounges and dining areas. All the wards had access to outdoor space. Patients told us that they had regular access to outdoor space and there was equipment outside for the patients to use, such as football and basketball.

All wards had a phone booth that patients could use to make a phone call in private, although on Wizard House patients were given a mobile phone, that the hospital paid for, to use whilst on the ward.

All patients we spoke with told us that the food was of a high quality. There was a choice of food from the menu each day that patients could choose. In addition to this, there were drinks and snacks available at all times on the wards which patients could either access freely (Wizard House) or patients could ask staff for (on psychiatric intensive care units). Patients we spoke with told us they could access these whenever they were hungry, even during the night. There was fresh fruit available on each of the wards that was replenished by the kitchens daily.

We carried out a tour of each of the wards during our inspection. We found that patients were not only able to personalise the wards but their own bedrooms as well. This included patients having photographs and mementos of home, along with artwork they had created in activities, displayed in their bedrooms. All patients were provided with a locker to store their personal possessions.

There was a full programme of activities on each of the wards seven days per week which included evenings.. During core hours Monday to Friday, the patients were expected to attend education. This took place off the wards and was facilitated by qualified teaching staff. The education department were going through the process of being registered with the Office for Standards in Education. Activities outside of these hours were facilitated by the

occupational therapy staff, ward activity facilitators and the ward staff. Activities included arts, crafts, baking, music groups and computer games. There was also the opportunity for leave off the wards either individually or in a group. A recent group activity was to a local bowling alley. Patients had an activity planner in their records and we saw evidence of these activities taking place. At the weekends, the activity planner tended to be more focused around visits from family and carers although for patients whose families lived too far away to visit there continued to be other activities available. There was also a skype facility for patients to chat to family and friends who were not able to visit.

Meeting the needs of all people who use the service

All wards had full disabled access. There were lifts to reach the first floor for people who had mobility issues. There were designated rooms for disabled patients, which were more spacious and had wet room style bathroom as well as equipment needed to assist with personal hygiene.

Information leaflets were available in different languages for patients or their families whose first language was not English. There were notice boards on each of the wards with important information on display. This included details on how to complain, advocacy contact details and activities that were ongoing in the local community. There were leaflets about different treatments and medications that patients could take and read in their own time.

As the adult side of the hospital was a specialist deaf unit, there was access to the hospitals British Sign Language interpreters should any of the patients require this. There was easy access to interpreters for patients whose first language was not English or indeed if their parents needed interpreters. We saw evidence of interpreters being booked when required for families at review meetings and discharge planning meetings for example. For patients who did not speak English interpreters were booked daily to facilitate communication between staff and the patient. The kitchen was flexible and was able to deliver meals to suit patient's specific dietary needs. We saw evidence of patients who needed a dairy free diet, special diet for religious needs and vegetarian diets being provided with appropriate food.

There was access from each ward to a multi faith room where patients could access spiritual support. This room included various religious books and items needed to pray such as a prayer mat. If patients wanted to speak to a religious leader, the hospital had good links within the local area. We saw evidence of different religious representatives visiting the wards at the request of patients. Staff also facilitated visits to churches, mosques and synagogues when patients were well enough to attend.

Listening to and learning from concerns and complaints

Between February 2016 and February 2017, the number of complaints for the service was 58. Five of these were upheld and none were referred to the parliamentary and health service ombudsman.

The improvements in complaints management, which we saw at the last inspection, had been maintained. The average time for closing complaints had dropped from 50 days to 30 days. The complaint letters sent were of a very high standard. Staff received training on complaints management at induction. Ward managers had received further training in investigating complaints. Investigations were patient centred and the focus was on learning lessons even where not upheld. In the child and adolescent mental health service, the clinical service manager had identified that staff attitude was a recurring theme in complaints and had made arrangements for staff to access customer care training.

During our inspection, we tracked the process of two complaints in the child and adolescent service. We found that both were dealt with in accordance with the policy. Patients and their parents had received feedback following the completion of the investigation and an apology given where there had been fault identified within the investigation.

Patients and carers we spoke with knew how to complain. We saw lots of information on how to complain around the ward areas and in patient's bedrooms. This was also included in the information given to patients and families on admission.

Are child and adolescent mental health wards well-led?

Good

Vision and values

Good

Child and adolescent mental health wards

The provider's values remained unchanged from the last inspection.

The values were:

- Helpful – "go the extra mile for service user, customer and team"
- Responsible – "do what you say you will do"
- Respectful – "treat people like you like to be treated yourself"
- Honest – "be open and transparent, act fairly and consistently"
- Empathetic – "be sensitive to others' needs, caring and compassionate."

Staff we spoke with knew what the values of the service were. The hospital used their values during recruitment and shared them during the induction process. Staff we spoke with used the language of the values when discussing care and treatment. This assured us that the values were embedded.

Since the last inspection, there had been a number of changes in the senior management team within the service. The hospital director, who was also the registered manager, had increased the number of clinical managers and they were office based within their relevant service. This had led to an increased presence at ward level and staff throughout reported good support from the senior management team.

Good governance

The governance structure was new at the last inspection. At the last inspection, we found that the governance structures were not always effective in identifying and managing risk and ensuring sustainable improvement.

At this inspection, we found that the governance structure was well embedded with clear lines of accountability and reporting. The hospital had appointed a lead psychologist as well as clinical quality and compliance manager. Although this was a very recent appointment, staff were positive about this approach and felt more included in the governance process of the hospital.

At the last inspection we found that, a number of policies were not up to date. Prior to this inspection we requested that the provider submitted their revised policies on seclusion and long term segregation, Mental Capacity Act, Deprivation of Liberty Safeguards, incident reporting and management, safeguarding adults and safeguarding children and young people. We reviewed the policies and found that they were compliant with the Mental Health Act Code of Practice, 2015 and the Care Act 2014.

There was a programme of rolling out policies, which staff had to sign to show they had read. Staff were following the system. The governance team had offered practical support by going to the wards and delivering the new policies and removing out of date policies, which was seen as positive by ward staff.

The system for sharing lessons learned was firmly embedded. Records showed and interviews with staff confirmed that lessons were shared in a number of ways including via team briefs, team meetings, email, and supervision. Learning was shared across all disciplines. A review of four incidents from the child and adolescent mental health service showed that incidents were investigated well. Local actions were identified and carried out and where appropriate learning shared across both adults and child and adolescent service. Staff and patients were supported and reflective practice encouraged. Minutes from governance meetings showed that incidents were reported appropriately up to the board and information communicated back to the ward. We saw examples where action plans had led to changes of systems to prevent recurrence and information shared across the hospital. Action plans identified time frames and the person responsible for completion of the action.

The hospital had appointed a new medical director who was running weekly medical advisory committee meetings. The role of the medical advisory committee is to ensure clinical services, procedures or interventions are provided by competent medical practitioners. Minutes showed these were well attended. There was good support from the hospital for doctors to access further training. Doctors were expected to undertake clinical audit and two audits had been started since the recent arrival of the medical director.

The improvements in complaints management which we saw at the last inspection had been maintained. Between July 2016 and December 2016, there had been 58 complaints. The average time for closing complaints had dropped from 50 days to 30 days. The complaints letters sent were of a very high standard. Staff received training on complaints management at induction. Ward managers had received further training in investigating complaints. Investigations were patient centred and the focus was on

learning lessons even where not upheld. In the child and adolescent mental health service, the clinical service manager had identified that staff attitude was a recurring theme in complaints and had arranged for staff to access customer care training.

The hospital used a recognised tool for assessing staffing levels and staffed accordingly. Staff on wards told us they were able to book agency staff when needed. Recruitment into nursing vacancies remained a challenge. The hospital were continually recruiting and trying different methods to attract staff. All consultant doctor vacancies had been filled and the staff were currently going through pre-employment checks before starting in post. The hospital had made improvements in how it recruited staff. We reviewed seven recruitment files and saw that hospital policies had been followed and all pre-employment checks completed. In one case, the person had disclosed a previous conviction. This had been correctly risk assessed and was continuing to be monitored.

Staff were aware of performance indicators and ward managers had access to performance reports. These were being used to improve the quality of care.

At the last inspection, staff were not always receiving appraisals. At this inspection, 91% of nursing staff were receiving appraisals. The overall figure was 96% for child and adolescent mental health services. All doctors were up to date with appraisals. The medical director had taken steps to strengthen processes for doctors to access training and supervision to support them to achieve continuing professional development.

There were improved systems for monitoring training, which had been recently introduced. This allowed ward managers to book and access local figures for training. If a person changed wards, the system would immediately identify any other training that was required.

In the child and adolescent mental health service, there had been a recent time and motion study to review staffing levels and how staff spent their time. This was to be used to help drive improvements. The number of wards had reduced from five to four and each ward now had a ward manager rather than shared between two.

The risk register included current risks and had been reviewed in line with identified timelines. Staff were aware of the risk register and how to submit items to it. The action plan that the hospital had devised following the last inspection had been shared with wards. Actions taken were visible for all staff.

Leadership, morale and staff engagement

Staff were involved in a number of different meetings. There were daily meetings between the senior management team where clinical managers fed back about the previous 24 hours. These were minuted and shared with the board. There were also weekly meetings with ward managers where information was shared. Staff reported feeling very supported by their managers, particularly the clinical service managers.

Staff gave us examples where they had made suggestions and been listened to. For example, when there had been a sharp rise in complaints at the end of the year, extra support had been supplied to ensure that complaints could be responded to as quickly as possible.

Sickness rates for the period February 2016 to January 2017 ranged from 1.8% on Primrose to 4.9% on Buttercup. The average across the hospital was 3.6% and the child and adolescent mental health service was performing at the hospital average of 3.6%. Staff turnover from February 2016 to January 2017 had a hospital average of 3.3%. The child and adolescent mental health service was performing better than the hospital average with a turnover of 2.5%.

There were clear whistleblowing processes and staff knew how to raise concerns and felt able to do so. An example was provided where the organisation had undertaken a thorough investigation in response to concerns raised.

There had been no bullying and harassment cases from February 2016 to January 2017.

Mostly staff felt empowered and supported to do their job. Ward managers were given leadership training. Staff told us they had good support from colleagues as well as managers.

All the staff we spoke with described saying sorry if something went wrong. Staff knew being open and transparent were part of their values and provided examples of where they had apologised. Staff received training in duty of candour at induction. There were effective systems in place for identifying whether an incident reached the duty of candour threshold and monitoring that the actions were taken. There had been

one incident in the child and adolescent mental health service since our last inspection that reached the duty of candour threshold. The service had been open and transparent and followed the requirements of the regulation. The hospital had written to the person and offered a meeting at their convenience, had apologised.

Commitment to quality improvement and innovation

The child and adolescent mental health wards were in the process of applying for membership of the Quality Network for Inpatient Child and Adolescent Mental Health Services.

The education department was in the process of registering with Office for Standards in Education.

Outstanding practice and areas for improvement

Outstanding practice

On West Hampton ward, they had introduced the recording in British Sign Language of the outcomes and actions from individual patients' care programme approach reviews onto a DVD for individual patients to watch. The person signing on the DVD was a staff member who knew patients well and understood their individual preferences of variations in signs, which meant the DVDs were tailored for patients to ensure effective and meaningful communication.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff on Bridge Hampton ward, a ward caring for patients most of whom had a learning disability, receive training in learning disability.
- The provider must ensure that staff on Columbus and Madison wards, specialist wards for patients with a personality disorder, receive training in personality disorder.
- The provider must ensure that staff working on the four wards caring for deaf patients attend training in British Sign Language to Level 2.
- The provider must review the blanket restrictions in relation to patients having access to mobile phones and ensure restrictions are individually assessed.
- The provider must review all restrictions including the restriction to patient bedrooms on the female wards.

Action the provider SHOULD take to improve

- The provider should ensure that staff on Columbus ward are aware of and have access to the ligature risk assessment.
- The provider should ensure that patient fridge temperatures remain within the recommended range.
- The provider should ensure that all staff attend the mandatory training and refresher training courses.
- The provider should ensure that multidisciplinary meetings and records reflect the patient's situation in relation to monitoring of serum levels if they have reduced or stopped smoking.
- The provider should ensure staff manage medicines safely, that the medicines have the name and dose of the medicine on the packaging.
- The provider should continue to nominate staff on the child and adolescents training course to increase the numbers of staff trained in this specialist area.
- The provider should review the observation documentation in place and ensure staff know how to complete the records.
- The provider should ensure that physical observation forms post administration of rapid tranquillisation are available to view on the wards.
- The provider should ensure that bank and agency staff are aware of the hospital's expectations regarding privacy and respect in relation to knocking on bedroom doors prior to entry.
- The provider should ensure that there is information on display for patients in all wards including how to complain and give feedback.
- The provider should consider access to a social worker for South Hampton ward.
- The provider should provide patients with information about the wards, to assist in their orientation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care A patient secluded from Upper West ward was deaf and the staff member conducting the observations could not sign, therefore the staff member could not effectively communicate with the patient. Both Upper West and Lower West wards had a mixed population of hearing and deaf female patients, zonal observations were in use and staff locked off the bedrooms from 9.30am to 12.45pm and 2pm to 5.45pm. Patients' access to mobile phones was not individually assessed. There were inconsistencies in the opportunity for patients to have access to mobile phones. Deaf patients had mobile phone access in Lower and Upper West wards, whereas hearing patients could only take mobile phones when out on leave. Patients on West Hampton, South Hampton and East Hampton wards had access to mobile phones; however, the other five adult wards did not. This meant the provider was not providing person centred care. This was a breach of Regulation 9(1)(b) (3)(b)(c)(d).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff working on Bridge Hampton ward, a ward caring for patients, most of whom had a learning disability, had not received training in learning disability.

This section is primarily information for the provider

Requirement notices

Staff working on Columbus and Madison wards, specialist wards for patients with a personality disorder, had low levels of attendance at personality disorder training with Columbus 32% and Madison 37%

British Sign language training levels for staff working on the four wards caring for deaf patients was low and meant there would be times where staff could not effectively communicate with patients.

This meant staff did not have the skills and knowledge to effectively support the group of patients.

This was a breach of Regulation 18 (1) (2) (a).