Stockton Hall

Quality Report

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

Ratings

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

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

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

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

Summary of findings

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

Overall summary

We rated Stockton Hall requires improvement because:

- The audit systems in place were not always effective. The audits did not identify the issues we found during the inspection for example in relation to the restrictive practice meetings, discharge planning records, the inconsistent use of systems to record information about the patients and implementation of Priory policies.
- Patients did not routinely have access to a nurse call system but staff ensured on an individual basis that alarms were in place when required.
- Patients capacity was not always recorded clearly in the patient files and staff were not always able to find them when asked.
- Discharge planning was not always recorded clearly recorded in the patient files.
- The provider had informed the Commission in 2016 they were going to develop the hospital and reduce two wards each with 24 beds to four wards each with 12 beds. The development had not happened yet although the plans are with the planning authorities. The delay in developing the two wards means they are tired and would benefit from being refurbished if the development is not started in the near future.

However:

- The hospital was clean and equipment was available to assist staff in their role.
- Managers had an active recruitment programme for staff. All staff were supported in their identified training and development needs. Where bank staff were used they worked on the one ward so that they got to know the patients.
- Managers effectively planned staffing resources to ensure that staff were available to spend the time required on direct patient care such as escorted leaves and attending hospital appointments.
- The process for reporting incidents and safeguarding concerns was robust and lessons learned were shared with staff. Although staff were unclear about any recent lessons learnt.
- Patients had access to different disciplines within the hospital to aid their recovery.
- Patients were involved in their own care planning and they told us staff were supportive and treated them with respect. They accessed a variety of activities and received support from an independent mental health advocate.
- There was a robust complaints process and when the hospital was found to be at fault they were honest about their mistakes and how they had put right the issue.
- The service could meet the diverse needs of patients and accessed specialist services to ensure patients could be fully involved with their care.

Summary of findings

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Requires improvement

Location name here

Services we looked at
Forensic inpatient/secure wards

Summary of this inspection

Our inspection team

The team comprised of four CQC inspectors, a Mental Health Act reviewer, three specialist professional advisors; two with a nursing background and one who was a doctor and an expert by experience (someone who has developed expertise through experience of similar services).

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and sought feedback from 48 clinical and non-clinical staff at five focus group meetings and from 12 patients at a focus group.

During the inspection visit, the inspection team:

- visited all seven wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- the Mental Health Act Reviewer looked at the seclusion suites across all wards
- spoke with 32 patients who were using the service and 11 carers
- sought feedback from seven patients at one focus group
- collected feedback from 16 people using comment cards
- looked at 24 care and treatment records of patients
- spoke with the senior managers for the hospital
- spoke with the managers or acting managers for each of the wards
- spoke with 37 other staff members, including doctors, nurses, support workers, an occupational therapist, a psychologist, a social worker, and housekeeping staff
- received feedback about the service from one commissioner
- spoke with an independent advocate
- attended and observed two multi disciplinary meetings and one care programme approach meeting
- carried out two short observational framework inspections
- carried out a specific check of the medication management on seven wards and reviewed 90 prescription charts
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this inspection

Information about Stockton Hall

Stockton Hall is a112-bed medium secure hospital for people over 18 with mental health problems, personality disorders, and learning disabilities. The hospital admits patients from across England. It is registered with the Care Quality Commission to provide the following regulated activities:

The hospital is part of Partnerships in Care Limited and in November 2016, it merged with The Priory group. Both Partnerships in care Limited and The Priory group are also part of the Acadia Healthcare organisation. They are registered for the following activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury.

The hospital had a registered manager at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

Patient accommodation comprised:

- Boston Ward – 24-bed ward for men with mental illness
- Kirby Ward – 24-bed ward for men with mental illness
- Hambleton Ward – Eight-bed ward for older men with mental illness
- Dalby Ward – 16-bed ward for men with mental illness and personality disorder
- Farndale Ward – 16-bed ward for women with mental illness and personality disorder
- Kyme Ward – 16-bed ward for men with learning disability
- Fenton Ward – eight-bed ward for men with autism spectrum disorders.

The last comprehensive inspection took place in 2016 and since then there has been one focussed inspection in 2017. The most recent inspection took place on 2 December 2017 and it was a focussed inspection looking at the staffing levels in the hospital. The hospital was found to be compliant with regulations.

All the wards have had a Mental Health Act Reviewer visit since the last comprehensive inspection and they identified a series of concerns including:

- blanket restrictions: - not allowed access to bedroom corridor when cleaning
- no unsupervised access to gardens
- dining room locked
- plastic cutlery
- reading section 132 rights
- privacy and dignity.

Stockton Hall provided action statements detailing how they would address the issues raised.

What people who use the service say

During the inspection, we spoke with 39 patients in one to one interviews and facilitated a patient focus group. We offered all patients the opportunity to speak with us during the inspection. We also collected feedback from 16 patients using comment cards.

Patients made positive comments that the wards were clean, and that they felt staff cared about them, were interested in their wellbeing, and were visible and available to help them on the wards.

All patients we spoke with told us that they had access to advocacy and knew how to make a complaint.

Summary of this inspection

Several patients told us there was nothing to do and they were bored. They said that they missed the staff who had left and since they had left there were fewer activities.

Patients on Farndale ward spoke positively about the staff and how well they worked with them. They told us they enjoyed going out in to town to the cinema and for a coffee to the local garden centre. One patient told us there wasn't enough time to do activities properly. They enjoyed woodwork and said they only had an hour at a time and they wanted more.

Patients told us they knew how to complain and all patients were aware of the advocacy service available on the ward. They said that their family and carers were informed and involved with their care and could telephone the service and attend ward meetings. They said they were offered opportunities to give feedback about the service and able to attend daily morning meetings. Most of the patients told us that they liked the food provided. Others told us the portion sizes were too small and they didn't enjoy the food.

We received feedback from 11 carers during the inspection to obtain their feedback on the service their relative had received.

Carers of patients told us that overall, they were happy with the care and treatment their relative received from the hospital and they knew how to make a complaint if needed. Several carers commented that they were not allowed to visit their relative without supervision from staff even though they felt safe. They told us they had been visiting for several years and they hadn't been able to have an unsupervised visit. They felt this was a breach of their human rights and the right to a family life.

Carers also told us that the doctors were approachable and they could discuss the care and support their relative was getting. They also told us they would like to know what the plans were for discharge.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

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

- Patients did not routinely have access to a nurse call system but staff ensured on an individual basis that alarms were in place when required.

However:

- The hospital was clean and well presented, and staff completed regular audits of infection control.
- Staff had access to emergency medications, grab bags and defibrillators.
- The prescribing practices at the service were good and pharmacists completed thorough medication audits.
- Patients told us that staff were available and visible and we did not see that staff vacancies had an impact on patient care as managers ensured shifts were filled.
- Safeguarding incidents were reported to the relevant authorities. All staff had received training in safeguarding procedures and there was a monthly safeguarding practice meeting where recent safeguarding events were discussed and any learning from the events was identified. A patient safety meeting took place following incidents that required a safeguarding alert to look at the safeguarding issues with the patient.
- The process for reporting incidents was clear and senior managers reviewed all incidents. Information about lessons learned was shared with staff through a bulletin. However, staff could not tell us of any recent lessons learnt.

However

- The majority of staff had undertaken mandatory training in areas important to their role. Mandatory training across the hospital had reached an average of above 84% in most areas. However the provider had recently introduced new training for managing violence and aggression, with a view to all staff being trained by May 2019. The provider should ensure all staff have the up to date training as soon as is possible to ensure safe and consistent working practice within the hospital.

Summary of this inspection

Are services effective?

Good

We rated effective as **good** because:

- Patients had access to an onsite multi-disciplinary team. Multi-disciplinary team meetings were effective, inclusive and informative for patients and staff.
- Therapy and recovery opportunities were available to patients at the hospital.
- Staff used recognised rating scales to measure patient outcomes and ensure treatment was effective. They employed two physical health care nurses to provide consistent medical support.
- All patients had care plans which were completed in a timely manner and regularly updated. Members of the multi-disciplinary team all input into patient care plans to ensure a fully collaborative plan of care.
- All staff had received supervisions and appraisals. Doctors had been revalidated.

However

- Patients capacity was not always recorded clearly in the patient files and staff were not always able to find them when asked.
- The restrictive practice meeting records did not show that restrictive practices and blanket restrictions were monitored and reviewed regularly with a view to reducing and eliminating them altogether.

Are services caring?

Good

We rated caring as **good** because:

- During the inspection, we witnessed care on all wards, which was respectful, compassionate, kind and responsive.
- Patients used words such as 'respectful' and 'polite' to describe staff and said that staff always had time to listen to them.
- Patients and if appropriate carers were involved in their care planning
- Feedback from patients was mostly positive about the way staff treated them.
- Patients were encouraged to access external resources such as the cinema, the local shops and garden centre
- Patients had the support of advocates who visited each ward weekly.

Are services responsive?

Good

We rated responsive as **good** because:

Summary of this inspection

- Patients and carers knew how to complain and the service managed complaints well, giving feedback and supervision to staff to enhance quality and being open and honest with patients when complaints were upheld.
- Patients had access to facilities and activities on all wards and were able to meet their recovery needs and emotional and spiritual needs.
- Patients and their carers had access to a variety of information regarding the service, the treatment offered and information about complaints. The admission information to aid orientation to the wards was high quality.
- Staff supported patients through their care plans and enabled them to explore their sexuality and gender issues.
- Patients had access to outside space which was safely enclosed and contained equipment to facilitate outside activities such as sports.
- Most patients had access to drinks and snacks throughout the day and night and told us that the food offered was high quality and there was choice available. Catering at the hospital was able to provide for patients with religious or cultural needs as all food was prepared on site.
- There were adjustments in place to ensure access to the hospital for people with mobility difficulties. Staff had access to interpreter's and information in different languages in order to support patients.

However:

- Discharge planning was not always recorded clearly recorded in the patient files.
- The provider had informed the Commission in 2016 they were going to develop the hospital and reduce two wards each with 24 beds to four wards each with 12 beds. The development had not happened yet although the plans were with the planning authorities. The delay in developing the two wards meant they were tired and would benefit from being refurbished if the development was not started in the near future.

Are services well-led?

Requires improvement

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

- The audit systems in place were not always effective. Staff audited areas of concern or high risk regularly. The outcome of these audits were mainly positive and reviewed at monthly governance meetings. However, the audits did not identify the issues we found during the inspection for example in relation discharge planning records and the inconsistent use of systems to record information about the patients.

Summary of this inspection

However:

- The management team were suitably qualified and experienced and were passionate about the service they delivered.
- The governance structures were thorough and well planned. All managers at the service were involved in the governance process to ensure changes and improvements began at ward level.
- Senior managers were aware of the risks and challenges for the service, and where they had identified the need for change had taken action to improve the service.
- Staff spoke highly of the management team and on the whole felt supported and effectively managed and supervised.
- Staff had training and development opportunities

Detailed findings from this inspection

Mental Health Act responsibilities

Staff participated in mandatory training in the Mental Health Act. The provider told us that over 75% of staff had completed this training.

The service had systems in place to ensure the proper implementation and administration of the Mental Health Act. They carried out regular audits of compliance with the provisions of the Act.

Care records across all services evidenced that staff routinely explained to patients their rights under the Mental Health Act. Patients had access to section 17 leave as granted by the responsible clinicians and staff clearly and correctly documented this.

Staff informed patients about their eligibility for an independent mental health advocate, who visited the hospital weekly to speak to patients. Newly admitted patients were automatically referred to the advocate.

All patients had consent to treatment forms stored with their care and treatment files. Medicines were always prescribed in accordance with the Act and they ensured that appropriate legal authorisation was in place to continue treatment after changes were made.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff participated in mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The provider told us that over 75% of staff had completed this training.

Despite the training on most wards staff had only a basic knowledge of the Act and its principles.

The social work team within the hospital carried out capacity assessments. Ward staff told us they assumed patients had capacity. We saw evidence that mental capacity assessments and best interest meetings had taken place although it was not easy to find this record in the care notes.

The service conducted audits of adherence to the Mental Capacity Act, and the service had a designated person who could support staff and provide advice, updates and education on changes to this legislation.

The provider had a Mental Capacity Act policy in line with the Code of Practice. The policy contained appendices with forms for recording capacity assessments and best interest decisions.

At the time of the inspection, no patients were being cared for at the service under a Deprivation of Liberty Safeguard.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

All wards were clean and tidy and appeared to have comfortable furnishings and seating, however on Boston ward we found some of the chairs appeared dirty and stained. Repairs were carried out in a timely manner. We saw cleaning schedules for the wards and domestic staff were on duty. Patients told us that the level of cleanliness on the wards was good and carers commented positively about the cleanliness of the visiting rooms. Staff carried out regular checks of the ward environment, which meant staff protected patients from the risk of infection.

None of the bedrooms had a nurse call system but each patient was assessed as to whether they needed a call bell. We saw evidence that where necessary specialist equipment had been provided for example a patient with epilepsy had been provided with specialist equipment that would alert staff if necessary. Staff were aware of the needs of patients they were supporting. They were able to describe what safeguards had been put in place to ensure patients who had been assessed as vulnerable from threatening behaviours of other patients. We saw evidence of this in the patients care plans. We found no link between incidents reported to the commission and the local safeguarding authority around safeguarding of vulnerable patients and the lack of a call bell system.

There was a Mental Health Act review of Boston ward prior to the inspection and we found that whilst both seclusion rooms were ready for use they were found to be unclean,there were several trip hazards as carpets were frayed or not stuck down, the dining room floor was found to be sticky, spillages were noted all day and the toilets were out of use awaiting repair, one since March. At this inspection, we found these issues had been resolved.

We also found on the seclusion room on Kirby ward the sealant on the floor joints in the seclusion room was peeling, the flooring was lifting at points by the wall and toilet and there was a brown smear on the wall. We also found on Dalby ward that the floor was peeling from the wall, there were marks on the cladding by the shower and the floor was not sealed where it met the doorframe. We raised these issues with the provider during the inspection, they had the flooring re-sealed, and extra cleaning had taken place to deal with the staining whilst we were on inspection.

The hospital had a high perimeter fence and staff constantly operated the main security entrance. People accessed the hospital through a secure “air lock” system from this entrance. Following an incident where a patient had forced their way through the airlock one of the doors had recently been replaced with a metal door making it heavier and harder to force. There were robust security protocols in place such as regular perimeter checks, frequent key checks, and CCTV surveillance. Security staff made patients and visitors aware of banned items before entering the wards. All wards had a secure “air lock” entrance with random search buttons for patients. The search button was pressed by patients returning to the ward and it would indicate whether staff should carry out a search on the patient or not. It was a random way of carrying out searches. Visitor access was restricted to designated visiting areas outside the main ward environment.

Requires improvement

Forensic inpatient/secure wards

Each ward had a ligature risk assessment in place for the environment. Where there were identified blind spots, staff observed patients according to their individual observation level to mitigate against the risks. The ligature audit tool had been changed from one used by the previous provider to one designated by The Priory . A separate audit was carried out for each room and staff added a patient risk profile rating to each audit. An example of this was for a toilet used by all the patients; the risk profile for the toilet was three, which equated to the highest risk category. The patient risk for this room was also three, which meant staff saw it as a high risk for all patients whether they were at risk of self harming through ligature, or not. We spoke with the clinical audit lead who explained that the rooms had their ligature risk assessment and they assessed the risk of a patient who might try to harm themselves with a ligature and where there was identified adjustments were made. An example of this was where a patient who had been assessed as being at risk of using a ligature to harm themselves could have used the hinges on the small window opening in their bedroom, they had fitted a mesh cover so the window could still be opened but the risk of ligature had been mitigated. Staff working on the wards did not appear to understand the rationale for including the patient on the ligature audit.

Each ward had a clinic room. They were found to be clean, tidy and clutter free. They did not have an examination couch but there was a clinic room elsewhere in the hospital where they had a couch. All of the clinic rooms had equipment for measuring patients' height, weight and physical observations such as temperature and blood pressure. They also contained emergency resuscitation equipment including a defibrillation unit. All staff had a key to access the clinic room so they could access the emergency equipment in the case of an emergency.Over 75% of staff had completed their immediate lifesaving training.

Medication was stored securely and regularly checked to ensure they remained in date and they had enough stock. We saw evidence of fridge temperatures being checked and there were some omissions in recording of fridge temperatures on Boston, Hambleton, and Kirby wards. A visiting pharmacist checked all medication weekly. Following the weekly checks, a summary statement was provided to indicate where any shortfalls were and what actions needed to be taken to correct the shortfalls. We found that issues raised through these checks had been addressed either on an individual basis or as a learning point in the hospital for all staff.The hospital had a nurse prescriber and they were able to offer support around medication when they were duty.. Immediate actions had been taken to ensure errors reduced and stopped. Ward managers told us that the management of medicines had improved since the external company had started weekly audits.

All wards except Hambleton ward had seclusion rooms, Kirby and Boston wards had two seclusion rooms. All seclusion rooms had adequate viewing panels to ensure there was no blind spots for staff observing seclusion. All rooms had windows, temperature control and an intercom for patients and staff to communicate. However, some windows were skylights and did not have blinds to block out the light if required. All had a visible, working clock and the rooms on Kirby and Boston wards had access to television and a sound system set behind a perspex panel. All patients had to leave the seclusion room in order to use the shower, toilet and sink facilities. Staff offered disposable bedpans and bottles to patients who were too disturbed to leave the room. Some patients told us they did not like to use these facilities in front of staff and were not always offered hand washing facilities after using the disposable bedpans and bottles.

Safe staffing

The whole time equivalent establishment levels and vacancies for each ward were;

- Boston ward - 11 qualified nurses, with five vacancies (45%) 21 nursing assistants with one vacancy
- Dalby ward - 13 qualified nurses with seven vacancies (38%) 13 nursing assistants there were no vacancies and the ward had two and a half extra staff.
- Farndale ward - 11 qualified nurses with five vacancies (45%) 18 health care assistants with two vacancies (5%)
- Fenton ward – six qualified nurses with five vacancies (83%) 10 health care assistants with two vacancies (10%)
- Hambleton ward – six qualified nurses with two vacancies (25%) 15 health care assistants with two vacancies (13%)
- Kirby ward - 11 qualified nurses with five vacancies (45%) 21 health care assistants with two vacancies. (9%)

- Kyme ward - 9 qualified nurses with three vacancies (55%) 18 health care assistants with two vacancies (11%)

The overall sickness rate across the hospital from February 2017 to February 2018 was at 3.8%. During the same period, there was a vacancy rate of 13.8% for all hospital staff. However, for the period 1 December 2017 to 2 March 2018 there were 32 vacancies for qualified staff.
The hospital director told us they had 10 qualified staff waiting to start and had an active recruitment system in place.

Stockton Hall employed their own bank staff who completed the same training as non-bank staff. This meant bank staff were known to the patients and they were familiar with the hospital processes. In the period 1 December 2017 to 2 March 2018, bank staff covered 1684 shifts and agency staff were used for 33 shifts. All shifts for this period were covered. Further information gathered during the inspection showed that bank staff covered 1006 shifts. Boston ward used 185, Kyme ward 168, Farndale 148, Fenton 154, Dalby and Kirby wards each used 145, and Hambleton 61 bank shifts.

The hospital has put in place a robust recruitment strategy with innovative welcome offers of financial remuneration as well as a benefits package, which included payment of the annual subscription fees to NMC as well as a training budget for Continuous Professional Development. Staff who recommend Stockton Hall to their friends could also receive a cash reward on completion of successful recruitment.

We looked at staffing level rotas during the past three months. Bank staff or regular staff worked additional hours and the manager adjusted staff according to the individual needs of the patients. They took account of increased observation levels or escorted visits away from the ward. Managers discussed staffing resources on a daily basis and additional staff were organised to meet planned patient needs. Ward managers were present from 9am until 5pm and not counted in the overall staffing numbers. Senior managers provided an on call system during evenings and weekends.

Most staff we spoke with said there was enough staff on duty to carry out physical interventions safely. They told us that staffing levels had improved in the last four months and if they were short of qualified staff then extra health care workers were brought in.

There was sufficient staff to manage patients who were nursed in seclusion or long-term segregation. In previous visits by CQC or the Mental Health Act Reviewer, issues about staffing and seclusion records had been raised. To counter this one of the ward managers had started a weekly seclusion group where staff could attend to discuss seclusion issues and to ensure staff were following good practice. We saw that designated staff observed patients in seclusion. Where patients where nursed in long-term segregation, MDT staff planned the most appropriate intervention with the patient. This meant that staffing levels could be adjusted according to the patients care plan and level of risk.

Staff said activities or Section 17 leaves were never cancelled. We saw on several wards that staff held section17 leave planning meetings to ensure leaves occurred as planned. Some staff commented that the impact of vacancies on the ward meant that there was not always enough time to spend with individual patients. Patients we spoke with said their leave was sometimes re-arranged or they did not get their planned individual time with their named nurse, as staff were too busy.

Six permanent consultant psychiatrists provided full time cover for each of the wards as well as on call cover. The medical director supported one consultant who covered two wards. Locum psychiatrists who were familiar with the hospital covered any gaps. All people we spoke with said the psychiatrists were accessible and visible on the wards. There was accommodation available on site for on call medical staff, which meant consultants could attend the ward quickly in an emergency.

All staff received mandatory induction training and yearly refresher training. The training lead used an electronic system to monitor compliance and informed staff three months in advance about their mandatory training requirements. Staff received reminder e-mails every month and said they knew how to access training.

The target for mandatory training compliance was 95% and we saw this was currently 84% overall.

Assessing and managing risk to patients and staff

Requires improvement

Forensic inpatient/secure wards

Stockton Hall hospital reported 124 incidents of seclusion between 1 September 2017 and 28 February 2018. Boston ward had the highest incidents of seclusion at 43. Fenton ward 26, Farndale ward 20, Kirby ward 19 Kyme ward nine and Hambleton and Dalby wards each had three incidents. There was one patient nursed in long term segregation. Information gathered during the inspection showed that for the period from 1 March 2018 to 16 May 2018 there were 35 incidents of seclusion with no incidents taking place on Hambleton ward.

There were 123 incidents of restraint on 38 different patients between 1 September 2017 and 28 February 2018. Boston ward reported the highest number of incidents of restraint at 43 on 11 different patients. Fenton ward had 26 incidents on five patients. Farndale ward had 19 incidents on five different patients. Kyme ward had 22 incidents on seven different patients. Kirby ward had eight incidents on six different patients. Hambleton and Dalby wards each had two incidents on two patients. Only one incident of restraint resulted in the use of prone restraint during this period.

Rapid tranquilisations had not been used during this time.

The provider had a reducing restrictive practice steering group, membership of which included clinicians and individuals who delivered the prevention and management of violence and aggression training across the division. The 'Safeward' initiative was introduced into training. The Safeward initiative focuses on soft words; talk down, positive words and relational security.

We found that there were several blanket restrictions, (this is rules or restrictions that are routinely applied to all patients without individual risk assessment to justify their application). On one ward, everyone used white plastic vending cups for hot and cold drinks. On another ward, we found that tea and coffee was held in the office because of the behaviour of one patient and this meant all patients had to request tea or coffee when they wanted a drink. On another ward every bedroom was routinely searched each month not necessarily with cause.

We spoke with the managing violence and aggression lead trainer and they told us that the National Framework for Personal Safety was the Priory's preferred training. They started rolling out the training on the 1 May 2018 and hoped to have it fully implemented by May 2019. They had eight trainers who had a full weeks training in the new method of restraint. They confirmed they did not teach 'floor work' and looked to use reasonable force if staff felt their lives were at risk. They told us that the skills staff already have are transferable from their current training to the new training. They confirmed they also used the 'safe wards' approach where soft words, diversion and distraction techniques were used. New staff and all the ancillary staff had 'breakaway' training and new staff were fully trained in the managing violence and aggression techniques within three months of their employment. The training for staff was based over four days with update training over two days. The hospital had also invested in three giant beanbags, that had been ergonomically designed to aid with de-escalation. There was a training manual for staff to refer to.

Staff used a range of measures to reduce the need for restraint and seclusion. For example, the use of positive behaviour support plans and "chill out rooms" for de-escalation and detailed analysis of patients' behaviour. On Dalby ward they had introduced a 'stop and think' group for patients. They were asked to bring two problems from the last 12 weeks to the group so they could be discussed. Staff told us that they had seen a reduction in the use of restraint since this group had started. Several patients' told us they enjoyed the group and found it useful because people were listening to them.

The psychologist told us patients were assessed on admission and throughout their stay. They used a range of assessment tools including; HCR20- Historical clinical risk; Liverpool University Neuroleptic Side Effect Rating Scale, ICD-10 which is an International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO), they use five forensic pathway, and EQOL.

Safeguarding practice was good. All staff received training in safeguarding. They were aware of safeguarding issues and scenarios. Managers raised alerts with the local authority safeguarding team as needed. During engagement meetings with the hospital, safeguarding issues were discussed. The safeguarding lead told us that all staff within the hospital have training in safeguarding and information provided prior to the inspection showed that 99% of staff had received the training. There was also a monthly safeguarding practice meeting where recent

Requires improvement

Forensic inpatient/secure wards

safeguarding events were discussed and any learning from the events was identified. A patient safety meeting took place following incidents that required a safeguarding alert to look at the safeguarding issues with the patient.

Track record on safety

Stockton Hall reported 10 serious incidents between 28 March 2017 and 5 October 2017. We saw that ward managers, security and staff from other Priory hospitals carried out investigations. Where possible patients were involved in the investigation and there was clear rationale as to why if they hadn't been involved.

Reporting incidents and learning from when things go wrong

All staff were aware of the reporting process and felt confident to report incidents. Nurses used the electronic incident reporting system to report incidents. Support workers did not use the electronic reporting system but reported incidents to the nurse in charge. Staff discussed feedback from incidents at handovers and ward clinical governance meetings.

Managers discussed incidents at the managers' morning meeting, the monthly clinical governance meeting and information about incidents was included in a governance pack held on every ward.

Staff said they had the opportunity for a de-brief following an incident on the ward. This ranged from informal peer support to formal sessions with the psychologist. Staff discussed incidents at multi disciplinary meetings and individually with patients.

The hospital had a lessons learned newsletter to share information about incidents across the service. However, none of the staff we spoke with said they had seen the newsletter and not all staff were confident about how lessons were shared.

Duty of Candour

We saw that where incidents had the potential to cause harm the duty of candour had been followed. This was in terms of patients and carers being given an apology and being involved in the investigation process and informed of outcomes.

Managers and staff were aware of their responsibilities under the duty of candour and training about duty of candour was included in staff induction.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Mangers and commissioners held weekly referral meetings to discuss referrals to the service. All patients had a pre-admission assessment and staff considered if admission was appropriate. Not all patients were assessed as suitable for admission.

The hospital used the recovery approach. They had been using an electronic care record called "path-nav" to help staff inform decisions about care. However, this system was incompatible with the systems of the new provider and not all staff could access it. They had introduced The Priory risk assessment tool, although not all staff were using it. Some staff continued to use path-nav and others used the Priory preferred tool Care Notes and there appeared to be some confusion amongst staff as to what they should be doing. Staff told us that it was 'like working in different hospitals' depending on which ward they were working on because of the different systems. We observed an individual care programme approach meeting. This meeting was chaired by the patient and they looked at issues around moving on from Stockton Hall, their medication and financial situation.

We looked at 24 care and treatment records across all wards and found staff consistently completed assessments and care plans within 72 hours of admission. We found most care plans were recovery orientated, personalised, comprehensive and up to date. Information included risk behaviours, meaningful activity, physical health and psychological needs. On Fenton and Kyme ward, we found that all records we reviewed had a comprehensive, up to date positive behaviour support plan, which staff reviewed regularly and where necessary patients on other wards also had a personal support plan. Patients who were assessed as having communication difficulties were referred to the speech and language therapist. The hospital employed two physical health nurses and contracted the services of a GP two days a week to ensure patients had a physical health

examination and ongoing monitoring of their physical health problems. Carers we spoke with were very confident that staff ensured their relatives' physical health care had been considered.

All patients received care under the care programme approach and staff carried out reviews of patients' care according to the care programme approach guidelines. Staff measured outcomes by recording health of the nation outcome scales on admission and at every care programme approach review.

Information about patients care was stored securely and available electronically or in paper records on the wards. We observed all staff were able to have up to date information about people's needs.

Best practice in treatment and care

We examined 90 patient prescription charts and 24 patient care records. We found that most prescribing was within the British National Formulary prescribing limits, where it exceeded limits regular high dose antipsychotic therapy checks were carried out. Medication prescribed on an as required basis was reviewed in the multi-disciplinary meeting to make sure it was still appropriate for staff to administer it.

Psychologists assessed all patients within three months of admission. Patients had access to a range of evidence based psychological therapies on an individual and group basis. This included dialectical behaviour therapy, cognitive analytical therapy, cognitive behavioural therapy and mental health and substance misuse awareness. Staff also offered anger management, psychoeducational and motivational enhancement groups. Psychological programmes were adapted to meet the needs of people with learning disabilities and the older patients in the service. Patients also accessed individual sessions around weight management, diabetes and sexual health.

Staff supported patients' recovery by offering a range of activities and opportunities. Patients applied for jobs in the 'shafe', this was a coffee shop and patients had decided the name. They were also involved in staff interviews. We met a patient who had been successful in applying for a job. Staff also supported patients with vocational training developing skills in the work environment such as handling money and customer service. Educational workshops supported patients with literacy, numeracy and computer skills. Staff organised woodwork, horticulture, music, drama and art sessions within a dedicated therapy area in the hospital. Occupational therapists supported patients with kitchen and domestic skills and to access local community resources. In preparation for the inspection, we held several focus groups and staff told us that each ward had lost their dedicated activity worker and that health care staff were being trained in activity work. These staff were part of the ward compliment so if the acuity on the ward was high they were pulled away from activity work and were engaged with patients in a clinical way. Patients also told us that staff did not always have time to engage in activities on the ward so they were bored. In discussion with the management of the hospital they told us the idea was to offer the activity training to all healthcare staff so that eventually there should be more activities available to patients.

Staff registered all patients with a local GP service that visited the hospital twice weekly. They employed two physical health care nurses who ensured all patients had routine physical health checks and ongoing monitoring of physical health problems including diabetes and asthma. Staff referred any patients who required specialist intervention such as a dietician to the local hospital. We saw evidence that a dentist, physiotherapist, chiropodist and optician visited the hospital regularly. Patients with diabetes had appointments for retinal screening and podiatry.

The hospital had a range of facilities and groups to improve physical health such as healthy eating groups. The hospital gym and sports hall were used for activities such as football and badminton. The hospital was a smoke free environment and patients and staff were offered smoking cessation support. We spoke with patients who were unhappy that they couldn't smoke in the hospital and several told us they could not smoke when they were on escorted leave. The Priory smoking policy did not give any guide lines as to patients being able to smoke when on section17 leave. Other patients told us they enjoyed the community walks and using the gym.

Clinical staff took part in clinical audits, which had led to improvements in the services. There was an audit lead and in information provided by the hospital prior to the inspection, they told us they were waiting on clarification via the Priory Audit Group what other national clinical audits they would be participating in.

Requires improvement

Forensic inpatient/secure wards

Medicines Management Audits were carried out by the pharmacist contracted to the hospital each week and they were divided in to four categories:

- MHA Compliance - Prescriptions corresponded with legal authority forms.
- Patient details - All required fields such as patient name, date of birth and allergy status were clearly stated.
- Prescription writing - Prescriptions were signed, dated and had all the required details.
- Administration Errors - Nurses had signed for the correct administration with no gaps on chart.

Pharmacy audits were then sent to the ward managers, charge nurses and consultants, and the results were reviewed at the monthly clinical governance meeting. Identified errors have included instances where staff did not sign for administered medication, another area concerned patient details not recorded on the drug card. These errors were discussed the governance meeting and addressed through clinical supervision.

Skilled staff to deliver care

All staff received regular supervision, for the period 1 February 2017 and 31 January 2018, the compliance rate for registered nurses was between 91 and 98% depending on which ward they worked. We saw at the inspection that supervision rate was at 100%. Staff told us that they received regular formal supervision and the registered manager and clinical lead for the hospital were always approachable if they needed further support. Between 87% and 92% of staff had an appraisal and all the doctors had completed their revalidation. Staff told us they found supervision useful and they didn't have to wait for supervision to speak to the ward manager if they needed advice or support. One member of staff told us they could opt out of supervision but this was not confirmed by other staff.

Specialist training was available to staff who requested it and it was relevant to the hospital. Staff told us the registered manager and the director of nursing services encouraged them to develop their skills. Staff told us The Priory had instigated a £250 continuous practice development that they could use to enhance their skills however they could only access extra training if they were up to date with their mandatory training. The nursing staff were a mixture of registered mental health nurses and specialist learning disability nurses.

Staff performance issues were initially addressed through supervision. In the period 1 February 2017 and 31 January 2018 four staff had been subject to the disciplinary process. Appropriate action and/or support was provided to ensure patients remained safe.

Multi-disciplinary and inter-agency team work

Multi-disciplinary meetings were held each week. Each meeting was attended by the following disciplines; consultant psychiatrist, named nurse or nurse in charge, occupational therapist, patient and carer if available. Advocates were also invited at the patients request or with their consent. The registered manager told us they were starting to invite nursing assistants in to the meetings as they worked closely with the patients.

We reviewed handover records for the last six weeks. Hand over templates included patient presentation, medication, physical observations and observed risks. Staff stated that only 15 minutes was allocated for handover although they usually exceeded this time. All available staff including ward managers and doctors attended handover meetings.

The service liaised with outside organisations to support repatriating patients back to their local areas. Representatives from clinical commission groups were regularly invited to multi-disciplinary meetings to assess the progress and needs of current patients. Representatives were provided with detailed information relating to the current care plan and patient needs following discharge.

Adherence to the MHA and the MHA Code of Practice

Since the last comprehensive inspection we have carried out Mental Health Act monitoring visits for each ward and in January 2018 we carried out a review of the use of seclusion in the hospital. The last Mental Health Act Reviewer visit found that the seclusion policy did not meet the Mental Health Act Code of Practice and the Mental Health Act Reviewer at this visit noted it still did not meet the Code of Practice.

Over the course of the Mental Health Act visits we found some common themes: blanket restrictions: - not allowed access to bedroom corridor when cleaning, room searches,

no unsupervised access to gardens, dining room locked plastic cutlery reading section132 rights, privacy and dignity. Whilst we have been provided with action statements on how these issues have been dealt with, they continually remain an issue of concern. We saw evidence at this inspection that several of the issues raised remained areas of concern for the patients.

We reviewed all the medication arrangements for patients detained under the Mental Health Act. This showed that the rules for treatment for mental disorder, were being met, with people being given medication authorised on the appropriate legal certificates.

We met with the independent mental health advocate that visited the hospital several times a week. They told us that staff were better at referring new patients for an initial visit. They also told us they were involved in multidisciplinary meetings and care programme approach meetings for patients who lacked capacity. They said the staff were supportive and they could approach the registered manager and director of nursing if they had any issues or concerns. The advocacy service provided a report each quarter with any recurring themes or concerns raised to the management of the hospital.

The hospital had a Mental Health Act administrator who ensured that the responsibilities of the Mental Health Act were met. As this was an independent hospital, admissions were planned so the MHA administrator could ensure that they checked the paperwork before patients were transferred into Stockton Hall.

There were good systems in place to support adherence to the Mental Health Act and MHA Code of Practice. The records we saw relating to the Act were generally well kept.

We found that the statutory systems were in place for planned admissions and the records seen showed us that patients had been informed of their rights of appeal against their detention. We found systems in place for staff to produce statutory reports where patients had appealed against their detention to first tier tribunals and hospital managers' hearings.

We found that staff at this location were aware of their duties under the Mental Health Act (1983). Over 75% of staff had received the relevant mandatory training.

Good practice in applying the MCA

Systems in place to record patients' mental capacity were not easy to navigate and staff were unable to show us where this would be recorded. Staff we spoke with told us patients were assumed to have capacity to make their own decisions and they involved the social work team for a more detailed assessment if they needed to be sure the patient understood what they were being told.

Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act.

We talked to the social work team who confirmed they had undertaken best interest meetings for patients who lacked capacity around the administration of medication covertly. This is where the medication is disguised in food to ensure it is taken. Another instance of a best interest meeting was around a patients diet and restricting it because they were diabetic.

All the patients were detained under the Mental Health Act and treatment decisions for mental disorder were therefore made under the legal framework of the Mental Health Act. Staff understood the limitations of the Mental Health Act for example, that capacity assessments were decision specific and the Mental Health Act could not be used for treatment decisions for physical health issues.

The Priory had a policy for the consideration of Deprivation of Liberty Safeguards(DoLs). There had been no applications for a DoLs in the period June2017 to January 2018.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

Staff were observed to interact with patients in a respectful and kind way. Throughout our visit, we heard conversation and laughter between staff and patients in communal areas. The staff demonstrated compassion and empathy when talking to and about the patients. We received 16 feedback forms and comments on these included:

- ‘I think the care given by nursing staff is outstanding’;
- ‘the staff try and help which is nice cause it shows they care’
- ‘I am listened to’

and one patient who wrote a letter for the commission to tell us ‘a brilliant staff team who are all willing to help anyone where they can’.

Patients said that staff were always polite and treated them with dignity, knocking before entering their room and respecting their privacy and belongings. Patients were able to decorate, personalise and maintain their bedrooms in line with their individual preferences.

Nursing and ancillary staff spoken with demonstrated a thorough personal understanding of each patient. All staff spoken with listed working with the patients as the best part of their role.

Staff were clear that they had not had need to raise any concerns of abuse but would feel free and safe to do so if necessary. Patients also said that they would feel safe to approach any member of staff with concerns or complaints and were aware of the advocates working with the service.

The involvement of people in the care they receive

All patients were invited to attend meetings regarding their care and were offered a copy of their care plan. For patients who did not wish to attend these meetings, their key workers would voice their wants and needs on their behalf. The care plans reflected this person-centred approach detailing a holistic range of personal information such as: religion, gender issues, sexual orientation, phobias, family involvement, “my goals”.

Staff were supportive of patients accessing different activities and services outside of the unit where appropriate. Patients were supported to make decisions about which treatments they received and there was evidence of mental capacity assessments being undertaken to support the patient’s capacity to make that decision. Patients were able to access independent mental health advocate, there was an advocate in the hospital on a weekly basis, and clear signposting towards advocacy services in communal areas. Some patients spoken with were unclear about discharge routes but where a patient knew what their discharge plan was it was clear that their opinions and preferences would be taken in to account when identifying an appropriate placement.

Feedback from carers was very positive, they spoke highly of staff attitudes and behaviours. One carer told us “I feel my relative is in a safe, secure environment which has enabled them to progress quickly. I feel their assessment of needs was accurate and the support put in place to assist him was reflective of those needs”. Another relative told us “my relative has been here more than three years and whilst I don't want them to be there but if he has to be somewhere I cannot fault Stockton Hall - they're brilliant”. Another said “when we visit we are treated with respect from all departments including security on arrival. They keep us up to date with all aspects of our relatives care and we have good contact with the doctor and ward staff”.

Each ward had their own weekly timetables, and held community meeting. Some of the wards had minutes and notices were written in large print and pictorial format to accommodate for individual communication needs. Patients were encouraged to utilise the community meetings or morning meetings with the staff to suggest activities or raise any concerns. There was also a monthly food forum, which allowed patients to discuss which foods they wished to be added, altered or removed from the menu. The menu had been designed in accordance with the patient group’s needs, ensuring the name, texture and appearance were appealing as well as the taste.

Community meetings were held on a weekly basis and information from these forums were fed back in to the governance meetings. The ward manager did a patient quality walk round where they discuss with the patients their experience of the service. Patients attend a monthly ‘Your Voice’ meeting and some changes made as a result of these meetings included; a new TV purchased on request, new furniture, caffeinated drinks on sale in the hospital shop and a range of activity resources for patient activities.

Patients were clear who was involved in their care, and how much information carers were given. Patients had identified in their care plan, which family members they wanted involved in their care.

Carers told us they were able to raise any concerns that they had about their relative’s care and described the staff in positive terms. They were invited to attend meetings

regarding the patient's care, sent copies of the care plan and minutes of any meetings that related to the patient. A carer told us that concerns they had raised regarding an aspect of their relative's care had been addressed and amendments made to the care plan.

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

Good

Access and discharge

The length of stay for patients at the hospital was between 487 and 2430, days. Boston ward had the lowest with 487 days with Kyme ward 2640 days.

Patients were referred to the hospital from all parts of the country for forensic medium secure services including people with mental illness, personality disorder, learning disabilities and autism. Referrals included people from NHS secure facilities and prisons. Staff assessed all patients within 24-48 hours of receiving a referral, although this time scale could be dependent on where the patient is residing. All admissions were planned when a bed was available.

The bed occupancy levels between September 2017 and February 2018 varied between wards and ranged between Farndale ward at 79% and Kyme ward at 99.50%.

Patients could move between wards during their admission. For example, some patients had moved from other wards to Hambleton ward in recognition of the needs of the older male population. Staff said patients only moved to different wards if their presentation changed. At our last comprehensive inspection in 2016, we identified that Boston and Kirby wards had large patient populations in an environment that needed updating. At this inspection the wards had not changed, they still had a large patient population and it remained a challenging environment for patients and staff. In 2016, we were informed that there were plans to reduce the number of beds on both wards by building two additional wards. Since that inspection, the owners of Stockton Hall had changed and the works to alter the two wards had not started. The hospital director told us they had submitted plans for approval and hoped to begin works in October 2018.

Stockton Hall reported no delayed discharges but staff said it was sometimes difficult to move patients on, as other services would not accept patients assessed ready for discharge to less secure environments. Where patients required higher levels of security, staff made appropriate referrals.

Staff told us they talked with patients about their recovery, including moving forward from the point of admission. However due to the recent takeover the systems used to record information had changed from path-nav to CareNotes. However some staff continued to use path-nav, even though not all staff could access these records, others used CareNotes. The healthcare records policy identified what information should be in the health records and this asked for the date of discharge or transfer and a discharge summary completed by the consultant. There was no reference to discharge planning. We looked at 24 care records and found little evidence that discharge planning was taking place.

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms and equipment on wards to support treatment and care. Not all wards had adequate quiet areas for patients to use. Fenton ward had two specially designed "chill out" rooms, which patients could access freely and were used for de-escalation. We saw most activities occurred off the ward during the week and patients told us there was less to do at weekends. Patients on Boston ward said it was too difficult to do activities because there was 24 patients and not enough staff and space.

Staff supported patients recovery by offering a range of activities and opportunities. Staff offered vocational training and patients applied for jobs in the Shafe and shop. Educational workshops supported patients with literacy, numeracy and computer skills. Staff organised woodwork, horticulture, music, drama and art sessions within a dedicated therapy area in the hospital. Occupational therapists supported patients with kitchen and domestic skills and to access local community resources. Patients could access the gym in the hospital .The hospital used the pets as therapy scheme and patients cared for a rabbit in the hospital.

Forensic inpatient/secure wards

Patients and staff worked together on sporting activities such as football, cycling, walking and running groups. All patients we spoke with felt access to these facilities helped their recovery.

Staff dispensed medicines in the clinic room. All wards had locked areas such as the dining room, kitchen and communal toilets. Staff told us this was for security reasons and doors were opened when needed. We observed robust security checks at lunchtime when cutlery was counted before patients were able to leave the dining room. Hot drinks and snacks were available until 11.00pm.

Patients had a key to access to their own bedrooms, which were spacious and personalised. Staff limited patients access to bedrooms to allow rooms to be cleaned or if patients didn't get up in the morning for breakfast. All wards had visitors' rooms and an outside garden area. Staff allowed patients' access to the garden at set times during the day. There was high perimeter fencing and anti-climb material on the roof.

Patients did not have access to mobile phones on the ward as these were on the list of banned items. Patients used phones located on the ward but not all patients felt they were private; however they could use the cordless office phone if necessary.

Food was of good quality and meals were freshly prepared from the hospital kitchen. The menu changed with the seasons and staff had sourced local supplies for halal meat. Patients and staff ate together on the ward and the same food was provided for patients and staff. Patients made menu choices the day before and we saw there was a wide variety of choice including vegan and vegetarian choices. Staff catered for special diets when required. Patients gave mixed views about the food and we saw that the chef attended patient community meetings to receive feedback.

Meeting the needs of all people who use the service

The hospital building design was appropriate to meet the needs of patients requiring disabled access if needed.

We saw that one patient who used a hearing aid had been supplied with a loop system so they could take an active part in meetings. We met several patients who were exploring issues around their gender identity. Staff were positive in their support of these patients. We saw that patients had care plans around their sexual health needs and these were detailed and enabled patients to explore their sexuality. All staff had mandatory training in equality and diversity. Staff were sensitive to the needs of patients and relationships between vulnerable people were recognised as safeguarding issues and managed appropriately. Staff told us there was a no touch policy between patients. Patients told us they were aware of the no touch policy, which meant those who wanted to form relationships would be prevented from doing so.

Patients who did not speak English as their first language were supported with an interpreter. Staff booked the interpreter in advance and the interpreter attended the ward for care programme approach meetings.

Staff supported patients to access appropriate spiritual support on the ward and the hospital had a dedicated multi-faith room that all patients could attend.

Information such as ward information guides and information about people's rights were displayed in ward areas. Information was provided in easy read format for people with learning disabilities. We saw some wards displayed the minutes from patient community meetings and information about activities.

Listening to and learning from concerns and complaints

There had been 71 complaints in the period 1 February 2017 and 31 January 2018. Seven complaints were upheld and 17 were partially upheld. None of the complaints were forwarded to the Ombudsman. Stockton Hall had a complaints officer who managed and investigated each complaint. They told me that they spoke to each patient who made a complaint either formally or informally. We saw evidence of written responses to patients and/or their families and where a complaint had been upheld an apology was made.

Patients told us they would tell their named nurse, key worker or the ward manager if they were unhappy. During the inspection, we observed patients interacting with various staff in a relaxed and easy manner. All of the staff gave the patients their full attention and listened carefully to what they were saying. We observed a community meeting where patients were supported to raise any concerns they had. An advocate told us they worked with patients who had concerns and complaints and they felt staff had listened to and acted on the information given by the patient in a positive manner.

Requires improvement

Forensic inpatient/secure wards

Staff knew how to proceed with complaints, raising them with the registered manager or director of nursing. Actions from complaints were discussed with staff during one to one sessions and team meetings.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

Staff who had worked at Stockton Hall since before the takeover were unable to identify the values of The Priory although they were still aware of the values of the previous provider. New staff did speak about the values and they were embedded in to staff induction.

Staff we spoke with could tell us who the hospital senior management team were and identified the director of nursing and the hospital director as people they could speak to if they had any concerns. Senior managers maintained a visible presence and met with patients and staff informally on the wards. Managers described an "open door" policy and staff felt comfortable to approach managers with their concerns.

The values were:

- We put safety first
- We out the people we care for at the centre
- We take pride in what we do and celebrate success
- We value our people
- Your voice matters

Staff knew who the senior managers of the hospital were and praised their accessibility. Staff felt that they could talk to either their ward manager or to the senior management team and that they would be listened to. The hospital had introduced three 'Speak out' guardians so that if staff did not feel able to go to their direct line manager or one of the hospital management team then they could speak to the guardians who would support them with their concerns. All of the staff we spoke with knew the name of at least one 'speak out' guardian.

Good governance

Following the recent merger between Partnerships in Care and Priory Healthcare several supporting systems used by staff had changed. Some systems used by the previous provider were not compatible with the systems used by The Priory. Some of the wards continue to use these systems, however not all staff could access them, such as path-nav. All wards had access to Care Notes the Priory preferred electronic recording system but staff on some wards continued to record information on path-nav, an electronic recording system previously used by the provider. Of the 24 care records we saw six referred to the system path-nav and staff told us that not all of them could access these notes. We also saw ligature audit tools being used as ligature risk assessments and staff appeared confused as to their function when we discussed them. Staff were clear about risks to patients but this was not backed up by the recording systems. In discussion with the management team it became clear that The Priory had not implemented a timetable for moving all their systems and paperwork to one unified system.

Stockton Hall had a hospital wide strategy to reduce restrictive interventions including the use of restraint and seclusion. A restrictive practice group met each month and we saw the minutes from the last five meetings of the 'reducing restrictive practice implementation group'. We saw that the issue of the monthly room searches was raised in November 2017 and they identified the issue should go back to the patient group meeting. Following the inspection information was provided about the reducing restrictive practice log. Any practice deemed to be restrictive was logged with a clear rationale for the restriction. This log was reviewed regularly and updated as necessary. However, the minutes of the restrictive practice group did not reflect the information contained in the log.

The hospital had a "see, think, act" model which is a guide published by the Department of Health to lessons learnt from serious incidents in secure health settings. We also saw a 'stop and think' group on one ward as well as reflective practice sessions for staff following incidents.

The hospital records showed that 90% of non-medical staff had received an appraisal and 100% of medical staff had been re-validated. Supervision and appraisal processes were in place and we saw appraisals were documented in all the records we reviewed.

There were sufficient numbers of staff of the right grades and experience on duty across all wards. Managers had an

active recruitment programme for staff. A number of incentives had been introduced to help recruitment and retention of staff. All staff were supported in their identified training and development needs. Where bank staff were used they worked on the one ward so that they got to know the patients.

Managers effectively planned staffing resources to ensure that staff were available to spend the time required on direct patient care such as escorted leaves and attending hospital appointments. However the impact of unplanned events such as incidents and seclusion meant that staff could not always spend the time they planned with patients such as one to one time or escorted leave.

Staff regularly participated in a range of clinical audits such as ligature audits, patient observations and medication audits. Results of audits were monitored and had action plans in place. Managers had oversight of progress with action plans through robust governance structures.

All staff understood how to report incidents including safeguarding concerns. There was an effective incident reporting and feedback system in place. Staff ensured any complaints from patients or their relatives were dealt with in a timely manner, and were open and transparent in their response.

The hospital had systems in place to help ensure staff adhered to the Mental Health Act and the Mental Capacity Act. Staff generally understood the principles of the Mental Capacity Act however, we found limited evidence of how capacity decisions were made and documented.

The hospital had an up to date risk register that took account of issues such as staffing and security. The register took account of risks rated as high, medium and low. Staff contributed to the risk register through a range of meetings such as the health and safety meetings and ward governance meetings.

Leadership, morale and staff engagement

Stockton Hall had a sickness rate of 3.8% for the period of 1 February 2017 and 31 January 2018. There were no staff absent from work due to work related illness or injury at the time of inspection. The service had a sickness policy and access to a human resources central team.

There were no reported bullying or harassment cases at the time of our inspection, or in the previous months. Staff were aware of the processes involved in either making complaints or raising concerns.

Since the takeover the management group had identified that staff morale was low and only 44% of the staff survey felt valued for the work they did. Staff told us they were anxious about their roles and they had seen some staff leave because of redundancies.

The Hospital Director commenced informal Your Say Forums which were held every Friday morning when they were in the hospital. There were also the formal monthly Your Say Forums, which were minuted, and actions fed back to the senior governance group. Stockton Hall also sent a representative to a regional Your Say Forums to and they feedback matters arising from the hospital Your Say Forum. In addition matters arising from the Regional Your Say Forum were feedback locally.

The hospital had re-introduced a local monthly staff recognition award where staff could nominate a colleague because of work they were proud of. Several staff we spoke with did not understand how it was decided who won the award and could see little or no benefit to it. A hospital events committee had been put in place in order to plan events for both patients and staff. They had organised several events such as sports relief week, a friends and family day, nurse day in May and future events include a charity bike ride and a village walk, for both patients and staff.

Staff were aware of the whistleblowing procedure and were confident to raise issues. Staff told us they would be happy taking any concerns to the registered manager or clinical lead.

Staff were open and transparent and explained and apologised to patients if something went wrong. We saw evidence of this in the complaints files. We observed positive interactions throughout our inspection between patients and staff.

Commitment to quality improvement and innovation

Stockton Hall provided information relating to The Commissioning for Quality and Innovation.This is a framework used by services to look at a continuity to improve how care was delivered. Compliance with Commissioning for Quality and Innovation and the NHS

Requires improvement

Forensic inpatient/secure wards

contract required the provision of data on the Recovery College, Reducing Restrictive Practice, Physical Healthcare and Care and Treatment Reviews. The service is also involved with the Quality Network for Forensic Mental Health Services annual peer review, this was an opportunity to benchmark the service against similar services with opportunities to share best practice.

Outstanding practice and areas for improvement

Outstanding practice

Staff worked with patients on an individual basis and we saw care plans that reflected the patients sexual orientation, sexuality and their gender identity. Staff enabled patients to explore their own self with dignity and respect.

We saw that where specialist equipment was required to support patients with their communication needs it was provided. A portable loop system had been given to a patient to enable them to be able to communicate at their pace.

Areas for improvement

Action the provider MUST take to improve

The provider must ensure patients can access to a nurse call system in their bedrooms.

The provider must ensure that the governance systems in place assess, monitor and improve the quality of service provided are embedded, in relation to the restrictive practice meetings, discharge planning records, the inconsistent use of systems to record information about the patients and implementation of Priory policies.

Action the provider SHOULD take to improve

The provider should ensure all staff have the up to date training for managing violence and aggression as soon as possible to ensure consistent and safe working practice within the hospital.

The provider should ensure that recording of a patient's capacity is clearly recorded in the patient files and staff should be able to find them when asked.

The provider should ensure that restrictive practices and blanket restrictions are monitored and reviewed regularly with a view to reducing and eliminating them altogether.

The provider should ensure that discharge planning is clearly recorded in the patient files.

The provider should keep the Commission informed about the proposed development of the hospital.

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
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Patients did not routinely have access to a nurse call system but staff ensured on an individual basis that alarms were in place when required.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The audit systems in place were not always effective. The audits did not identify the issues we found during the inspection for example in relation to the discharge planning records, the inconsistent use of systems to record information about the patients and implementation of Priory policies.**