Chadwick Lodge

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?	Good
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 Chadwick Lodge as good because:

• Patients had excellent access to psychological therapies. The psychology team operated a comprehensive, patient focused, individualised service (for example, by adapting therapy sessions to suit the needs of patients with autistic spectrum disorder or a learning disability). Their dialectical behaviour therapy program had been specially adapted for use in forensic services, and it linked with the cognitive behavioural therapy and trauma work. Psychology staff offered individual and group work to address offending behaviours and substance misuse. They also provided specialist treatment programs for male sex offenders and females with a history of fire setting. Members of the psychology team recently organised a national conference on the therapeutic treatment of sex offenders.

• Staff received necessary training, an appraisal and regular supervision, and medical staff completed revalidation. Most staff had a high level of morale and job satisfaction. They felt supported by their peers and by managers and felt able to raise concerns without fear of victimisation. In general, staff were highly positive about the organisational transition from the Priory Group to Elysium Healthcare.

• The hospital has been an accredited member of the Royal College of Psychiatry quality network for forensic mental health services, for both medium and low secure services, since 2011.

• Occupational therapy was available to patients on all wards. Therapists operated a model which focused on a holistic, person centred and recovery based approach. Staff helped patients to build and maintain independence by encouraging them to participate in activities of daily living. Patients had the opportunity to undertake voluntary work, either within the hospital or in the local community, appropriate to their ability and individually assessed level of risk. Patients had access to a hospital gym and to outside space, including a courtyard area with an enclosed sports pitch.

• Staff provided patients with extensive support to prepare them for admission to the hospital; moving to a different ward; or, being discharged from the hospital. Care plans we looked at were individualised, holistic, recovery focused and up to date. Occupational therapy staff were fully trained to use the model of human occupation screening tool, to help inform patient care plans. Patients had an initial physical health assessment and good access to ongoing physical healthcare.

• Patients were extensively involved in their own care and the running of the service. Staff sought patient input when devising risk assessments and care plans, and patients attended meetings about their own care. Some patients had helped to devise a handbook for newly admitted peers and a DVD to inform and promote the psychological therapy program to students and other patients. Patients attended ward daily meetings, community meetings and regular forums. They were involved in the recruitment of all staff at every level and had the ability to nominate elements of the service for upcoming audits.

• Staff treated patients in a caring, respectful and responsive manner. Staff displayed a high level of understanding of the individual needs and abilities of patients. Staff supported patients to maintain personal relationships during their time within the hospital. Patients had access to general and statutory advocacy services, and interpreters were available to patients as needed.

• Patients had a comprehensive risk assessment on admission, which was regularly reviewed and updated. Staff applied blanket restrictions only when justified and minimised their use where possible. Staff used good policies and procedures for observing and searching patients and the ward environment, in order to minimise identified risks. All wards had a detailed ligature risk assessment in place. Most wards had anti-ligature fittings throughout.

• Staff reported incidents appropriately and investigated them thoroughly. Staff met to discuss learning from incidents and received support following serious incidents. Staff used learning from incidents to inform future practice and they shared feedback on incidents with patients.

Summary of findings

• Escorted leave and ward activities were rarely cancelled due to staff shortages. Staffing levels were managed to meet changing demands on each ward. The hospital had a low number of vacancies for substantive staff. All bank workers were required to complete the same induction program and ongoing training as substantive staff. Where possible, managers attempted to deploy bank workers to wards they were familiar with.

However:

• The closed-circuit television cameras in the seclusion suite on Berridale ward did not have a protective pane of Perspex, to prevent them potentially being removed by a patient. If a patient were to remove one or more of the cameras, staff would not be able to maintain an unbroken view of the patient.

• Social workers had a supervision rate below the hospital's stated target of 85%, with a rate of 76%.

• Some patients told us they sometimes found the diction of some members of staff difficult to understand and this could impact on communication between staff and patients. They told us that this was more evident with members of bank staff who were not familiar with those patients.

• Some patients we spoke with were unhappy with the quality of food provided.

• Some patients we spoke with told us they would like there to be more activities on offer.

• Some nursing assistants we spoke with did not feel engaged with senior managers and the process of change within the hospital. They reported feeling undervalued by managers. Staff commented negatively about the introduction of a new arrangement for taking breaks.

• The rehabilitation ward had a blind spot in the garden area which had not been risk assessed, the laundry room was untidy and dirty and the kitchen fridge needed de-frosting

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards	Good	
Long stay/ rehabilitation mental health wards for working-age adults	Good	

Summary of findings

Contents

Good

Chadwick Lodge

Services we looked at

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

Summary of this inspection

Our inspection team

Team leader: Steven McCourt, Inspector, Care Quality Commission.

The team that inspected Chadwick Lodge comprised six Care Quality Commission (CQC) inspectors, one CQC inspection manager, one CQC assistant inspector, three specialist advisors (a psychiatrist, a psychologist and a nurse with experience of forensic services) and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses mental health services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme and because the provider had recently changed from the Priory Group to Elysium Healthcare. We re-inspect services where a provider has recently changed.

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 these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

• visited all nine wards, looked at the quality of the ward environment, and saw how staff were caring for patients

• spoke with 41 patients who were using the forensic service and seven patients using the rehabilitation service

• spoke with the hospital director and four clinical ward managers

• spoke with 50 staff members, including consultant psychiatrists, associate speciality doctors, psychologists, occupational therapists, social workers, nurses, nursing assistants, ward clerks, an advocate, the chaplain, a Mental Health Act administrator, the fitness instructor and the yoga instructor

• held four focus groups for occupational therapists, clinical ward managers, social workers and psychologists respectively

• received feedback from eight relatives

• spoke with the visiting pharmacist

• carried out three short observational framework for inspection exercises

• attended and observed three multidisciplinary clinical meetings, one care program approach meeting, one dialectical behaviour therapy (DBT) consult group meeting, one hospital morning meeting, one ward daily business meeting and one patient forum meeting

• looked at the care records for 49 patients and the medicine records for 80 patients

• looked at policies, procedures and other documents about the service.

• spoke with one external health professional

• spoke with one external commissioner.

Summary of this inspection

Information about Chadwick Lodge

Chadwick Lodge hospital is situated in Eaglestone, Milton Keynes. It provides male and female forensic secure and locked rehabilitation services for patients with mental health needs, who may also have related issues such as substance misuse. It offers care and treatment to patients with a dual diagnosis of mental illness/personality disorder and mild learning disabilities. It is located on two adjacent sites, called Chadwick Lodge and Eaglestone View.

On 01 December 2016, the hospital transitioned from its former organisation, Priory Secure Services, to a new provider, Elysium Healthcare.

The hospital has capacity for 94 patients, accommodated on eight forensic secure wards and one locked-rehabilitation ward.

Avon, Berridale and Calder are medium secure wards for men with 10 beds each, and Deveron and Irvine are low secure wards for men with 14 and 10 beds respectively. Eden is a medium secure ward for women with eight beds and Jordan and Kenly are low secure wards for women with 11 and 10 beds respectively. Hope House is an 11 bedded rehabilitation ward for women experiencing mental ill health and specialising in the treatment of women with personality disorders.

Chadwick Lodge is registered to carry out the following regulated activities:

•Treatment of disease, disorder or injury.

•Diagnostic and screening procedures.

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

•Accommodation for persons who require treatment for substance misuse.

Our most recent comprehensive inspection of the hospital took place in September 2015. We rated the hospital as 'good' overall, but 'requires improvement' in the safe domain. We returned in December 2016, to inspect the safe domain alone. We improved our rating for the safe domain to 'good'.

We conducted a Mental Health Act review visit to the five secure wards on the Chadwick Lodge site (Avon, Berridale, Calder, Deveron and Eden) on 31 October and 01 November 2017.

What people who use the service say

We spoke with 41 patients within the forensic secure wards and four carers. Most were highly complimentary about the way staff treated them and the care they provided.

Patients were very positive about the psychological therapies they had received and how the program had assisted them to move through the care pathway into less restrictive wards. Patients who had moved to other wards within the hospital told us that they felt well prepared and supported prior to and following the transition.

Patients told us they valued their involvement in the recruitment process for new staff. They felt very positive about having helped to choose suitable candidates and in so doing, developed their own confidence and skills

Patients reported that escorted leave and ward activities were rarely cancelled due to staff shortages. However, some patients told us they would like there to be more activities on offer.

Some patients were unhappy with the quality of food provided.

Some patients told us they sometimes found the diction of some members of staff difficult to understand and this could impact on communication between staff and patients. They told us that this was more evident with members of bank staff who were not familiar with those patients.

We spoke with seven patients within the rehabilitation ward and four carers. Comments about care provided at

Summary of this inspection

Hope House were very positive and highly complementary. Every patient and relative we spoke to commented on the high quality and effectiveness of the therapy programme. Patients said staff were caring and kind towards them. All of the patients we spoke with felt actively involved in choosing and making decisions about their care and treatment. Patients told us that the staff had the patients' best interests in mind and that they tried to equip patients well for an effective and safe life in the community.

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

We rated safe as good because:

• The wards had good lines of sight and staff mitigated risks from any blind spots by use of mirrors or staff observation. All staff carried alarms and there were call points in each room.

• All wards had a detailed ligature risk assessment in place. Most wards had anti-ligature fittings throughout. Any remaining ligature risks were appropriate to the patient group on the ward and further mitigated by increased levels of staff observation. Emergency equipment was available and regularly checked.

• The hospital had three seclusion facilities that were all modern, purpose-built and suitably appointed. Staff followed hospital policies for the use of seclusion and long-term segregation and only used either of those interventions as a last resort. Staff recorded and reviewed episodes of seclusion and long-term segregation appropriately. There was a recently established protocol for transferring patients to any of the seclusion suites.

• Escorted leave and ward activities were rarely cancelled due to staff shortages. Staffing levels were managed and changes made to meet the needs of each ward. The hospital had a low number of vacancies for substantive staff. All bank workers were required to complete the same induction program and ongoing training as substantive staff. Where possible, managers attempted to deploy bank workers to wards they were familiar with.

• Staff received mandatory training in a combination of face-to-face sessions and elearning modules. The compliance percentage for each course was over 75%.

• Staff used an electronic system to report incidents. Incidents records were appropriate and thorough. Staff met to discuss incidents, including serious incidents at other Elysium hospitals. They received appropriate support following serious incidents. Staff used learning from incidents to inform future practice. Staff shared feedback on incidents with patients.

• Patients had a comprehensive risk assessment on admission and they were regularly reviewed and updated following any significant occurrence. Staff applied blanket restrictions only when justified and minimised their use where possible. Staff used good policies and procedures for observing and searching patients and the ward environment, in order to minimise identified risks.

Summary of this inspection

• Senior managers were flexible and responded well if the needs of patients' increased and additional staff were required.

• Staff received training in the use of de-escalation techniques and only used physical restraint after de-escalation had failed.

• The hospital contracted the services of an external pharmacist who conducted regular audits of medicine storage and administration. The pharmacist participated in clinical governance meetings, met with the responsible clinician on a regular basis and delivered medicines management training to staff.

However:

• The closed-circuit television cameras in the seclusion suite on Berridale ward did not have a protective pane of Perspex over their front, unlike the cameras within the central seclusion suite. There was therefore a possibility that a patient could pull the unprotected cameras from their mountings on the walls of the Berridale suite, thereby removing the ability for staff to maintain a constant view of the patient.

• The furnishings and decor in the secure wards on the Eaglestone View site were in need of an update. The hospital had an agreed program of capital expenditure, which included the refurbishment of those wards.

• There was a blind spot in the garden area of Hope House which had not been risk assessed. The laundry room was untidy and dirty and the kitchen fridge needed de-frosting.

Are services effective?

Good

We rated effective as good because:

• Patients in the forensic secure service had excellent access to psychological therapies. The psychology team operated a comprehensive, patient focused, individualised service. The dialectical behaviour therapy program had been specially adapted for use in forensic services, and it linked with the cognitive behavioural therapy and trauma work. Psychology staff offered individual and group work to address offending behaviours and substance misuse. They also operated specialist treatment programs for male sex offenders and females with a history of fire setting.

• Patients in the rehabilitation ward, Hope House, had access to a variety of psychological therapies which were all based on the dialectical behavioural therapy model as described as best practice in the National Institute for Health and Care Excellence guidance. This therapy was delivered either on a one to one basis or in a group setting, as part of the treatment programme and psychologists,

occupational therapists, social workers and the nursing team had all been trained in dialectical behavioural therapy. Skilled staff delivered care and treatment. Throughout Hope House the multidisciplinary team was consistently and pro-actively involved in patient care.

• Staff completed a thorough multidisciplinary assessment before admitting each patient. Care plans we looked at were individualised, holistic, recovery focused and up to date. The prescribing of medicines followed National Institute for Health and Care Excellence guidance.

• The staff team for each ward came from a variety of professional backgrounds, including medical, nursing, psychology, social work and occupational therapy. A contracted pharmacist spent one and a half days at the hospital each week. Staff had the appropriate level of experience and qualifications, and had access to a wide range of relevant training courses.

• Patients had an initial physical health assessment. The ongoing monitoring of physical health was appropriate and patients had good access to physical healthcare. Staff supported patients to stop smoking, aided by nicotine replacement therapies.

• Staff received an appraisal and regular supervision. Medical staff completed revalidation. All staff participated in reflective practice sessions, where they could discuss instances of good practice and areas for development.

• There were strong working relationships within each ward team and between different teams throughout the hospital. Staff attended a range of regular meetings and managers participated in a monthly peer audit system. Staff worked proactively to foster strong working relationships with external agencies.

• Mental Health Act records were in good order and staff received appropriate support from Mental Health Act administrators. Most staff had completed up-to-date training in the Mental Health Act. Patients could access specialist independent mental health advocacy services as required.

• Staff received up-to-date training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Patients could access specialist independent mental capacity advocacy services as required.

• There was evidence of best practice and that all staff had a good understanding of the Mental Health Act 1983 (MHA), the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and the associated Codes of Practice.

However:

Summary of this inspection

• Social workers had a supervision rate below the hospital's stated target of 85%, with a rate of 76%.

• Patients did not have access to dental appointments within the confines of the hospital, which meant that patients could miss appointments if they had not been granted leave.

Are services caring?

Good

We rated caring as good because:

• Staff treated patients in a caring, respectful and responsive manner. Staff displayed a high level of understanding of the individual needs and abilities of patients.

• Staff supported patients to maintain personal relationships during their time within the hospital.

• Staff had implemented initiatives to involve patients in their care and treatment. Patients had extensive involvement in the operation of the service. Patients had helped to devise a comprehensive handbook, given to newly admitted patients. Patients attended ward daily meetings, community meetings and regular forums. Patients were involved in the recruitment of all staff at every level. Patients had the ability to nominate elements of the service for upcoming audits. Patients made a DVDs about the therapies provided at the hospital.

• Patients were involved in their own care. Staff sought patient input for risk assessments and care plans. Staff actively encouraged patients to attend multidisciplinary meetings and care program approach (CPA) meetings and staff encouraged them to participate in discussions about their care.

• Staff helped patients to build and maintain independence by encouraging them to participate in activities of daily living. Some patients had a weekly food budget, went shopping for their own food and prepared all their own meals.

However:

• Some patients told us they sometimes found the diction of some members of staff difficult to understand and this could impact on communication between staff and patients. They told us that this was more evident with members of bank staff who were not familiar with those patients.

Are services responsive?

Good

We rated responsive as good because:

• Patients had a clear care pathway to move between medium secure wards and less restrictive low secure wards. Staff supported

Summary of this inspection

patients when they were moving to another ward or preparing for discharge from the hospital. Staff worked with other agencies to ensure that appropriate aftercare services were in place for discharged patients.

• Information about the complaints process was displayed on ward notice boards and in the handbook issued to new patients. Staff discussed themes from complaints received during clinical governance meetings.

• Occupational therapy was available to patients on all wards, with a variety of therapy sessions offered. The occupational therapists operated a model that focussed on a holistic, person centred and recovery based approach. There was a varied and recovery orientated programme of therapeutic activities available.

• Patients had the opportunity to undertake voluntary work, either within the hospital or in the local community, appropriate to their ability and individually assessed level of risk.

• The general environment within the hospital was suitable for people with restricted physical mobility and patients with specific physical needs had necessary adjustments made to their bedroom and en suite toilet and shower facilities.

• Psychologists adapted therapy sessions to suit the needs of patients with autistic spectrum disorder or a learning disability.

However:

• Some patients we spoke with were unhappy with the quality of food provided, however catering staff had begun to meet individually with patients to discuss their dietary requirements and preferences

• Some patients we spoke with told us they would like there to be more activities on offer.

• There was no facility within the hospital to enable patients with restricted mobility to have a bath.

• Patients did not always receive timely feedback on complaints they had made.

• The communal areas within Avon, Berridale and Calder wards were noticeably cold on the first day of our inspection visit. Some patients wore outer garments within those areas of the wards. We highlighted this issue to the hospital director at the end of that day.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

• The hospital has been an accredited member of the Royal College of Psychiatry quality network for forensic mental health services, for both medium and low secure services, since 2011. Staff were working to obtain national accreditation for their dialectical behaviour therapy (DBT) program.

• Members of the psychology team recently organised a national conference on the therapeutic treatment of sex offenders. The hospital is planning to host a conference for forensic services during 2018.

• Most staff had received an appraisal, received regular supervision and had completed mandatory training.

• The hospital had a comprehensive governance framework, which incorporated clinical governance meetings, daily planning meetings, staff and community meetings and a range of meetings, each of which focussed on a particular element of service delivery. Staff had access to an electronic dashboard that clearly displayed important information for the running of each ward.

• A member of the senior leadership team visited each ward on a monthly basis, to assess the experience of patients and staff. Clinical ward managers completed a monthly peer audit of a random selection of patient care records from a different ward.

• Most staff had a high level of morale and job satisfaction. They felt supported by managers and able to raise concerns without fear of victimisation. Most staff were highly positive about the organisational transition from the Priory Group to Elysium Healthcare. Staff met regularly to discuss current issues and recent events. Each ward had a monthly reflective practice session and staff could give feedback in regular staff forum meetings.

However:

• Some nursing assistants we spoke with thought that senior managers had an insufficient level of presence on the wards.

• Some nursing assistants we spoke with felt less engaged with the management structure and the process of change within the hospital. They reported feeling undervalued by managers.

• The recent introduction of a one hour and 47-minute break had had a detrimental effect on the morale of some staff.

Detailed findings from this inspection

Mental Health Act responsibilities

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

• The hospital has two Mental Health Act administration officers. Managers we spoke with felt they had a good level of support from their Mental Health Act administrator.

• At the time of our inspection visit, 92% of staff had received updated training in the Mental Health Act and Code of Practice.

• Specialist independent mental health advocacy (IMHA) was available to all patients, IMHAs visited the unit on a regular basis.

• The Mental Health Act documentation was present and easily available on all the files we reviewed.

• There was active involvement of the independent mental health advocacy (IMHA) service.

• Copies of up-to-date section 17 leave forms were kept in a file accessible in the nurses' office. The forms were comprehensive, clearly detailing the levels, nature and conditions of leave.

• Assessments of patients' capacity to consent to treatment were available, at the point that T2 certificates were issued and reviewed. Both T2 and T3 certificates were reviewed in line with the provider's policy. Staff conducted regular audits of T2 and T3 consent certificates; medicine charts; and section 17 leave documentation.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received training in the use of the Mental Capacity Act 2005 and Deprivation ofLiberty Safeguards (DoLS). Over 93% had completed training in the 12-months prior to our inspection. There was a Mental Capacity Act policy in place and staff told us about the principles and how they applied to their patients.

Where there was a change in a patient's mental health, the psychiatrist carried out a mental capacity assessment to ascertain whether or not the patient had the capacity to consent to, or refuse treatments. For patients who might have impaired capacity, capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis with regards to significant decisions, and patients were given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. Patients were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the patients' wishes, feelings, culture and history.

At the time of our inspection visit, no patients were subject to Deprivation of Liberty Safeguards authorisations (DoLS). Staff had not submitted any DoLS applications during the 10-month period December 2016 to September 2017 and this was appropriate. (Deprivation of Liberty safeguards aim to make sure that people in hospitals are looked after in a way that does not inappropriately restrict their freedom).

Patients could access specialist independent mental capacity advocacy (IMCA) services as required.

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	Good	Good	Good	Good	Good
Long stay/ rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Good

Safe and Clean ward environment

• Staff ensured the physical and procedural security at Chadwick Lodge was provided to a consistently good standard. Staff were knowledgeable about the provider's policies and procedures and applied these effectively, to ensure the safety of patients, visitors and staff.

• There were eight secure wards at the hospital, across two sites separated by a minor road. The Chadwick Lodge site has five secure wards and the Eaglestone View site has three secure wards.

• Both sites had single entrances through which everyone had to enter or leave the building. Reception staff operated a single airlock at each entrance. An airlock is an additional locked area to pass through before gaining access or exit to or from the hospital. This means a person does not have direct access into or out of the hospital unless the doors are unlocked by reception staff. This helps to strengthen security in and out of the hospital. All staff, patients and visitors had to record their details when entering or leaving the building.

• All staff carried alarms and there were call points in each room. This ensured that patients and staff could call quickly for assistance if there was an incident. During our visit we saw that staff responded quickly to alarms.

• Staff carried their keys and alarm in a leather pouch attached to a belt around their waist. This promoted safety on the wards by ensuring that keys could not be misplaced or taken from staff.

• The wards had good lines of sight to observe patients. Staff mitigated risks from any blind spots by use of mirrors or staff observation. The bedroom corridor on Deveron ward was not visible from the main nursing office. To mitigate this, staff maintained a permanently manned, secondary nursing station at the end of the bedroom corridor.

• The hospital had a closed-circuit television system installed throughout. Some parts of the system had been installed immediately prior to our inspection visit, and so were not yet operational at that time.

• All wards had detailed ligature risk assessments in place, which staff had recently reviewed as part of an annual review process. Most wards had anti-ligature fittings throughout. Any remaining ligature risks were mitigated by extra levels of staff vigilance. Patients known to have a higher risk of using a ligature had had this identified in their individual risk assessment.

• All wards were gender specific, which meant the provider complied with guidance on same-sex accommodation.

• Each ward had a clinic room, which was clean, tidy and well stocked with necessary medicines and equipment. The clinic rooms were locked and the nurse in charge held the key.

• Emergency equipment was stored in all wards in well-equipped, tidy and clean clinical rooms. An automated external defibrillator and anaphylaxis pack were in place in a centrally accessible office between two wards. Ligature cutters were accessible. All emergency equipment was checked daily to ensure it was fit for purpose and could be used in an emergency.

• The Chadwick Lodge site had three seclusion suites. One was located on Berridale ward, one was on Eden ward and the third was centrally located, on the link corridor. There were no seclusion suites on the Eaglestone View site.

• The seclusion suites were all modern and purpose-built. All three had an en suite toilet, hand basin and shower, with anti-ligature fittings. They also had a bed, a television screen built into the wall and a clock to enable patients to be oriented to the time of day. They were all equipped with a viewing panel and a closed-circuit television system, to enable staff to view the patient in every area of the suite. The closed-circuit television cameras in the seclusion suite on Berridale ward did not have a protective pane of Perspex over their front, unlike the cameras within the central seclusion suite. There was therefore a possibility that a patient could pull the unprotected cameras from their mountings on the walls of the Berridale suite, thereby removing the ability for staff to maintain a constant view of the patient.

• All three seclusion suites had an intercom system, to allow two-way communication between staff and the patient.

• Staff used a recently established protocol for transferring patients to the seclusion suites. The protocol addressed the route to be taken to the seclusion suite, depending on whether the patient was behaving in an agitated or aggressive manner. It also addressed the issue of negotiating the intervening road, should a patient from the Eaglestone View site need to be transferred to one of the seclusion suites on the Chadwick Lodge site.

• All wards were clean and tidy. The furnishings and decor in the secure wards on the Eaglestone View site were in need of an update. The hospital had an agreed program of capital expenditure, which included the refurbishment of those wards.

• A regular cleaning roster was kept in the ward office and staff could request additional cleaning when they needed it such as preparing a bedroom for a patient admission.

• Staff completed a weekly environmental audit which included reviewing infection control and prevention. This ensured that patients were protected against the risks of infection. We observed staff adhering to infection control principles, including handwashing.

• Each ward had an environmental risk assessment completed, as part of an ongoing annual process. Staff had also completed an environmental risk assessment for ward gardens and the central courtyard on the Chadwick Lodge site. Staff completed an overall risk assessment for different types of activity that patients had access to.

Safe staffing

• Hospital management had introduced a new shift pattern in October 2017. Since then, ward staff worked 7:00am until 7:30pm on day shifts and 7:00pm until 7:30am on nights shifts.

• Each ward had an established number of nurses and nursing assistants for every shift. Day shifts had at least two qualified nurses on duty, plus the specified number of nursing assistants. Night shifts had at least one qualified nurse on duty, plus the specified number of nursing assistants.

• The hospital's workforce co-ordinator managed staffing needs as they changed across all wards.

• The establishment figure for substantive staff across all eight secure wards was 60 whole time equivalent qualified nurses and 105 whole time equivalent nursing assistants. The hospital had a total of 1.0 whole time equivalent qualified nurse vacancies and 9.5 whole time equivalent nursing assistant vacancies, the highest level was on Kenly ward, which had 3.5 whole time equivalent nursing assistant vacancies.

• The hospital operated a staffing bank, to augment the substantive workforce. All bank workers were required to complete the same induction program and ongoing training as substantive staff. Agency and bank nurses were familiar with the wards.

• Managers avoided the use of agency workers whenever possible. During the three-month period 17 July to 16 October 2017, 16 shifts were filled by agency staff due to sickness or absence. The highest level was on Eden ward, with 11 shifts. The hospital used one local agency and tried to use workers who were familiar with the ward or hospital whenever possible.

• There were 502 shifts filled by bank staff due to sickness or absence during the three-month period 17 July to 16 October 2017. The highest level was on Eden ward, with 167 shifts. A total of 14 shifts remained unfilled by bank or agency staff during the three-month period 17 July to 16 October 2017.

• Where possible, managers attempted to deploy bank workers to wards they were familiar with. However, some patients told us they sometimes found the diction of some members of staff difficult to understand and this could impact on communication between staff and patients. They told us that this was more evident with members of bank staff who were not familiar with those patients.

• Staff turnover during the 12-month period October 2016 to September 2017 was 8%. This represented 21 leavers, from the total of 257 substantive staff.

• Staff sickness during the six-month period April to September 2017 was 4%. The ward with the highest sickness level was Kenly ward, with 12%.

• Staff and patients we spoke with reported that escorted leave and ward activities were rarely cancelled due to staff shortages. Patients had regular one-to-one time with their named nurse.

• When staff needed to carry out a physical intervention, staff from neighbouring wards attended to assist in safely managing the situation.

• Medical staff told us they were happy with the on call arrangements in place to provide day and night medical cover. Doctors took turns to provide on call cover one week out of every seven. Doctors told us that the arrangement to provide cover for an unbroken period of seven days was not an onerous one, due to the low demands placed upon them. Doctors operated a system for confirming out of hours prescriptions by text message or email to two qualified nurses. Medical staff then wrote up the prescription during the next working day.

• All staff received mandatory training to enable them to carry out their roles. Staff received training in a combination of face-to-face sessions and e-learning modules. The compliance percentage for each course was over 75%.

Assessing and managing risk to patients and staff

• We examined the care records for 43 patients, with a sample taken from all eight wards. All patients had a comprehensive risk assessment on admission and these were regularly reviewed and updated following any significant occurrence.

• Staff used a recognised risk assessment tool, version three of the historical clinical risk management-20 (commonly known as HCR-20 v3), to provide structure and guidance to the assessment, management and reduction of known risks for each patient. The multidisciplinary team regularly discussed individual risks during their review meetings.

• Staff only applied blanket restrictions when justified and minimised their use where possible. Senior staff met on a monthly basis to specifically look at ways to reduce the use restrictive practices within the hospital.

• Staff used good policies and procedures for observing and searching both patients and the ward environments, in order to minimise identified risks.

• At the time of our inspection visit, 91% of staff had received up-to-date level 1 safeguarding training and 80% of staff had received up-to-date level 3 safeguarding training. Staff we spoke with were familiar with the process for raising a safeguarding concern and told us they received feedback on the outcome of safeguarding investigations. We saw evidence that staff discussed safeguarding issues in meeting minutes we looked at.

• The number of safeguarding alerts raised during the 12-month period 01 November 2016 to 31 October 2017 was 65. Of these, 16 related to Kenly ward, 16 related to Eden ward, 13 related to Avon ward and 13 related to Deveron ward.

• Staff received training in the use of de-escalation techniques and only used physical restraint when de-escalation was unsuccessful. At the time of our inspection visit, staff were receiving a new training package for the therapeutic management of violence and aggression, in the form of a five-day classroom-based course.

• There were 173 episodes of restraint during the six month period, April to September 2017, involving a total of 27 different patients. The wards with the highest number of restraint episodes were Kenly ward with 95 and Eden ward with 63.

• Two of the episodes of restraint were in the prone position, one on Avon ward and one on Eden ward. Prone restraint is a face towards the floor position which should be avoided as it can compress a person's ribs and limits an individual's ability to expand their chest and breathe. Additionally, a person who is agitated and struggling needs

extra oxygen and they are unlikely to get sufficient oxygen in the prone position. Two episodes of restraint resulted in staff administering rapid tranquilisation, one on Avon ward and one on Eden ward.

• Staff used an established policy for the administration of rapid tranquilisation and only administered that intervention as a last resort. Physical observations of patients who had received rapid tranquilisation were appropriate and followed hospital policy. Staff recorded instances of the use of rapid tranquilisation as an incident in the hospital's electronic system.

• There were four episodes of seclusion during the six month period, April to September 2017, two involving a patient from Deveron ward; one involving a patient from Avon ward; and one involving a patient from Calder ward.

• There were two episodes of long-term segregation during the six month period, April to September 2017, one involving a patient from Avon ward and one involving a patient from Eden ward.

• Staff used an established policy for seclusion and long-term segregation and both were only used as a last resort. The hospital had a recently established protocol for transferring patients to the seclusion suites. Staff recorded and reviewed episodes of seclusion and long-term segregation appropriately.

• The hospital contracted the services of an external pharmacist who spent one and a half days each week at the hospital. The pharmacist visited all wards and conducted regular audits of medicine storage and administration. The pharmacist attended quarterly hospital clinical governance meetings, met with the responsible clinician on a regular basis and delivered medicines management training to staff.

• We looked at the medicines charts for 71 patients. Staff recorded the administration of medicines appropriately.

• A stock of medicines not yet individually prescribed was stored in the clinic room on each ward. The stock was maintained in order to ensure that each ward had a supply of medicines in the event that the individual stock for any patient ran out. A nurse on each ward conducted a weekly stock check every Wednesday night.

• Children were not allowed to visit the wards. There was one family room in the reception block of the Chadwick Lodge site and a second family room in the therapy corridor of the Eaglestone View site.

Track record on safety

• The hospital reported that five serious incidents had occurred during the 12-month period October 2016 to September 2017.

• Managers had used learning from the death of a patient at another hospital to improve the safety for patients at Chadwick Lodge. As a result, patients at Chadwick Lodge switched to the use of hessian bags for shopping trips.

Reporting incidents and learning from when things go wrong

• The hospital introduced a new electronic incident reporting program in April 2017. Staff received training in how to use the new system.

• We looked at hospital electronic incident records. The reporting of individual incidents was appropriate and thorough. Staff we spoke with knew what incidents to report and how to report them.

• Staff had received training in the duty of candour. There was a policy which set out the importance of being open and transparent, following incidents. Staff met with patients to share information about incidents and discuss learning points and changes in practice.

• Each ward submitted a daily report for the hospital handover meeting every morning. The ward report included all incidents that had taken place during the preceding 24-hour period. Hospital managers and multidisciplinary team members discussed incidents at the hospital handover meeting and reached agreement on the appropriate course of action to take in each case.

• The hospital received learning from incidents at other Elysium sites via email alerts and corporate and regional governance meetings. This information was shared with staff via hospital clinical governance meetings.

• A monthly clinical governance meeting took place on each ward. We looked at the minutes of several of these meetings, and saw evidence that staff had discussed issues arising from incidents.

Good

Forensic inpatient/secure wards

• Ward managers, senior managers and the estates department attended an additional monthly meeting, where they discussed learning points from incidents and examples of good practice.

• Ward managers facilitated informal debriefing sessions with their staff as soon as possible following an incident. Psychologists led the formal debrief process. In addition to holding group sessions, they sought to identify any individuals who were in need of extra help.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

• All patients had a multidisciplinary assessment prior to admission. The process involved assessment of a paper referral, followed by one or more visits by multidisciplinary team members to the patient's present location. This process sometimes took three to four months to complete in relatively complex cases.

• Each patient had an initial care plan which had been formulated at their point of admission.

• We looked at the care records for 43 patients. Care plans were individualised, holistic, recovery focused and up to date.

• Each patient had a physical health assessment at the point of admission and a designated physical health nurse led the ongoing monitoring of physical health.

• Patient care records were stored electronically. Records were stored securely and were accessible to staff. Information from the incident recording system was automatically fed through to the individual care record of involved patients.

Best practice in treatment and care

• We looked at the medicine charts for 71 patients and saw that staff followed the National Institute for Health and Care Excellence guidance for prescribing medicines.

• Patients had good access to physical healthcare. Staff described how they developed physical health care plans. Staff had received training in assessing and effectively managing physical health care needs. Staff supported the integration of mental and physical health and developed comprehensive care plans that covered a range of physical health conditions such as diabetes, cardiac conditions, cancer, incontinence, addictions and breathing problems. The hospital had a practice nurse who carried out regular physical heath monitoring checks on patients, including those with an identified health concern, such as diabetes. Patients did not have access to dental appointments within the confines of the hospital. We saw one instance where a patient had missed a dental appointment because they had not been granted leave.

• There was a no smoking policy throughout the hospital. Patients could only smoke during unescorted leave. Patients could access nicotine replacement therapies in the form of lozenges, patches or inhalers via prescription.

• Patients had excellent access to a range of psychological therapies. The psychology team were experienced and well trained. They operated a comprehensive, patient focused, individualised service. The hospital's dialectical behaviour therapy (DBT) program had been specially adapted for use in forensic services, and it linked with the cognitive behavioural therapy (CBT) and trauma work that was also provided. Psychology staff offered individual and group work to address offending behaviours and substance misuse. They also operated specialist treatment programmes for male sex offenders and females with a history of fire setting. The fire setting program was operated in conjunction with Buckinghamshire Fire Service. Patients we spoke with were very positive about the psychological therapies they had received and how the program had assisted them to move through the care pathway into less restrictive wards.

• The hospital was in the process of introducing a new interactive computerised system, to which staff and patients will have joint access. The system was to provide a visual representation of the person's therapeutic pathway, identifying specific treatments and goals for each individual.

Staff assessed patients using the health of the nation outcome scales (HoNOS). The assessment uses 12 measurement scales, and is completed before and after a course of treatment, to assess the effectiveness of the treatment.

• Staff engaged in clinical and management audits. These included ensuring good physical healthcare for patients, risk assessing ligature risks on the wards, reviewing enhanced observations, ensuring patients had positive behaviour support plans and reducing the use of seclusion and restrictive practices. Staff regularly audited risk assessments and care plans to ensure quality and completion.

Skilled staff to deliver care

• Staff for each ward came from a variety of professional backgrounds, including medical, nursing, psychology, social work and occupational therapy. A contracted pharmacist spends one and a half days at the hospital each week. Staff had the appropriate level of experience and qualifications.

• All new staff (including new members of bank staff) completed a face-to-face induction program. All staff were trained in the therapeutic management of violence and aggression before entering clinical areas. New staff were allocated a supervisor who assisted them to complete their on-ward induction program, as well as the healthcare certificate where relevant.

• The hospital's stated clinical supervision target was 85%. The supervision rate during the nine-month period January to September 2017 was 91%. The only staff group who had a supervision rate below the 85% target were social workers, who had a supervision rate of 76%.

• All staff participated in reflective practice sessions, where they could discuss instances of good practice and areas for development.

• During the 12-month period October 2016 to September 2017, 94% of non-medical staff received an appraisal. During the same 12-month period, 100% of the eight medical staff completed revalidation.

• A total of seven staff had been suspended from work due to poor performance during the eight-month period March to October 2017. Following the completion of the disciplinary process, one member of staff was dismissed. In other cases, staff were issued with a warning or instructed to complete relevant training.

• All occupational therapy staff were fully trained in the use of the model of human occupation screening tool (MoHOST). This is a tool used to allow therapists to gain an overview of a person's occupational functioning and is used to inform patient care plans.

• Staff had access to a wide range of training courses, to equip them to care for their patients. Examples of training courses offered were: illicit substance awareness, personality disorders, diabetes, dialectical behaviour therapy (DBT), trauma, clinical risk assessment, communication and record keeping, gender specific awareness, infection control, observation and engagement, conducting physical searches, physical and relational security, seclusion awareness and controlled drugs.

Multi-disciplinary and inter-agency team work

• Senior personnel from across the hospital met every morning to discuss the preceding day's events and that day's schedule.

• The multidisciplinary team from each ward held a weekly meeting to discuss patient care.

• Staff attended a handover when commencing their shift. We observed care reviews and clinical hand over meetings on most wards and found these to be highly effective, and inclusive.

• There were effective working relationships between the managers and multidisciplinary team members from different wards. They attended meetings together and managers participated in a monthly peer audit system, where they each reviewed a sample of patient care records from a ward not under their control.

• The hospital proactively sought to foster good working relationships with external agencies, such as the police and local authority adult safeguarding team. The hospital had an allocated police community officer, who was their first point of contact should any issues arise. The hospital presented examples of recent collaborative work they had completed with the police, such as establishing a protocol for hostage situations. The hospital had quarterly strategic meetings with the local authority adult safeguarding team. The fire setting treatment program was jointly operated with Buckinghamshire Fire Service.

• There was an occupational therapy team, which worked across the wards. The team consisted of occupational therapists, and occupational therapy support staff. A gym was available for patients.

Adherence to the Mental Health Act and the Code of Practice

• The hospital has two Mental Health Act administration officers. Managers we spoke with felt they had a good level of support from their Mental Health Act administrator.

• At the time of our inspection visit, 92% of staff had completed recent training in the Mental Health Act.

• Patients could access specialist independent mental health advocacy (IMHA) services as required.

• The quality of patient electronic care records, including Mental Health Act documentation, was good and they were well organised.

• Staff conducted regular audits of T2 and T3 consent certificates; medicine charts; and, section 17 leave documentation. A T2 certificate is completed when a detained patient has the capacity to consent to treatment and has done so. A T3 certificate is completed when a detained patient either withholds or is incapable of giving their consent to treatment. A T3 is completed by a second opinion appointed doctor (SOAD). Section 17 leave is the Section of the Mental Health Act which allows the responsible clinician (RC) to grant a detained patient leave of absence from hospital.

• We conducted a Mental Health Act monitoring visit to five wards (Avon, Berridale, Calder, Deveron and Eden) on 31 October and 01 November 2017.

• Our Mental Health Act reviewers found that information regarding the independent mental health advocate, Care Quality Commission, the hospital complaints process and general patient information was not adequately displayed on the wards. During this inspection visit, we found that information was appropriately displayed and available to patients.

• Our Mental Health Act reviewers found that the ward telephones Calder ward and Eden ward did not offer patient privacy to make and receive calls. Patients also informed them that the cordless phone was often not working. By the time we conducted this inspection visit, staff had purchased two new cordless telephones each for Calder ward and Eden ward.

• Our Mental Health Act reviewers found that staff explained to patients their rights as required by section 132 of the Mental Health Act every six months in line with hospital policy. However, patients did not consistently have their rights explained following a change of circumstances, such as on renewal of detention. By the time we conducted this inspection visit, staff had set in place measures to ensure that patients had their rights explained following a change in circumstances. For instance, Mental Health Act administrators had started to email the primary nurse and ward manager to prompt them to explain rights when a patient's section is changed or they have a renewal hearing; or, there is a change in the patient's treatment.

• Our Mental Health Act reviewers found that not all patients had been assessed as to whether they had capacity to consent to treatment and that capacity assessments were completed yearly and there was no evidence that they were regularly reviewed in multidisciplinary meetings. However, during this inspection visit, we found that staff had started to assess and record capacity appropriately.

• Our Mental Health Act reviewers found that there was a lack of activities and that the gym had not been operational for some time. A new fitness instructor had commenced employment shortly after the Mental Health Act review visit and before this inspection visit. They had started a basic gym timetable to afford patients from every ward access to the facilities when we conducted this inspection visit. Some patients we spoke with told us they would like more activities to be on offer.

• Our Mental Health Act reviewers found that a patient who was prone to exhibit challenging, aggressive and abusive behaviour towards other patients and staff did not have a behaviour support plan in place to evidence how staff were managing the situation. However, during this inspection visit, we saw that patients who were known to exhibit challenging, aggressive and abusive behaviour had a suitable positive behaviour support plan in place.

• Our Mental Health Act reviewers found that some patients had been subject to urgent treatment under section 62 that did not meet the requirements for authorisation in the Act and its Code of Practice. Staff had not requested the input of a second opinion appointed doctor (SOAD) when ongoing urgent treatment was given and that section 62 forms were not always uploaded to the patient's electronic care records. Prior to this inspection visit, staff had

amended the template for the hospital morning meeting, to ensure that all section 62 use was reported the next day. In addition, Mental Health Act administrators had started to monitor the use of section 62 treatment to ensure that it was not used inappropriately or excessively.

• Our Mental Health Act reviewers found that it was difficult for patients to see staff speaking to them through the intercom system in all three seclusion rooms; and, the hospital did not have clear protocols for the transfer of patients into the three seclusion rooms. Prior to this inspection visit, the hospital had adapted all three seclusion rooms to ensure that the patient could have direct eye contact with staff when talking to them through the intercom system. Staff had also established a new protocol for the transfer of patients from all wards, to each seclusion room, including the transfer of patients from the Eaglestone View site, across the road to the Chadwick Lodge site.

• Patients told our reviewers that they were unhappy with the quality of food provided. Some patients echoed this view when we spoke to them during this inspection visit.

• Our Mental Health Act reviewers found that care plans were generic in nature and did not show evidence of minimum restrictions on patient's liberty, consideration of the patient's diverse needs, or that identified risks were being matched to an appropriate care plan. During this inspection visit, we found that care plans had largely addressed the issues identified by our reviewers.

• Our Mental Health Act reviewers were unable to obtain evidence that patients had received copies of their leave authorisation forms. During this inspection visit, we found that staff recorded when they offered patients a copy of their leave form.

Good practice in applying the Mental Capacity Act

• Staff had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Over 93% had completed training in the 12-months prior to our inspection visit. There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy in place.

• Where there was a change in a patient's mental health, the psychiatrist carried out a mental capacity assessment to ascertain whether the patient had the capacity to consent to, or refuse treatments. For patients who might have impaired capacity, capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis regarding significant decisions, and patients were given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. Decisions about patients were made in best interests, recognising the importance of the patients' wishes, feelings, culture and history.

• At the time of our inspection visit, no patients were subject to Deprivation of Liberty Safeguards authorisations (DoLS). Staff had not submitted any DoLS applications during the 10-month period December 2016 to September 2017 and this was appropriate.

• Patients could access specialist independent mental capacity advocacy (IMCA) services as required.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

• We observed many instances in which staff interacted with patients in a caring, respectful and responsive manner. We saw staff assisting patients both with practical tasks and in respect of their current mental and emotional state.

• Staff displayed a high level of understanding of the individual needs and abilities of patients, during their interactions with patients and the way they spoke about patients with their colleagues and with members of the inspection team.

• Staff demonstrated a strong understanding of relational security and de-escalation techniques to proactively assist patients who became agitated or distressed.

• Patients we spoke with were complementary about the way staff treated them. However, some patients told us they sometimes found the diction of some members of staff difficult to understand and this could impact on communication between staff and patients. They told us that this was more evident with members of bank staff who were not familiar with those patients.

• We saw evidence of extensive work provided to support patients to maintain personal relationships during their time within the hospital.

Good

Forensic inpatient/secure wards

• Carers we spoke with told us they were happy with the care provided by staff.

The involvement of people in the care they receive

• Staff completed thorough pre-admission assessments, in order to best match prospective patients with the service provided at Chadwick Lodge. Members of the multidisciplinary team conducted visits to the service (several visits, in the case of more complex cases) where the prospective patient was located, in order to prepare the patient and staff alike, for the new admission to Chadwick Lodge.

• Patients had helped to devise a comprehensive handbook, to inform and assist new patients admitted to the hospital. However, some patients we spoke with told us they had not received a copy of the handbook.

• Every ward held a daily meeting for patients and staff each morning. During the meeting patients discussed their planned activities and schedules for the day. They also raised any issues that may be affecting their care and treatment.

• Patients participated in planning their care and were offered a copy of their care plan documents.

• Staff helped patients to build and maintain independence by encouraging them to participate in activities of daily living such as doing their own laundry and preparing their own food. Some patients had a weekly food budget, went shopping for their own food and prepared all their own meals.

•Chadwick Lodge was developing a recovery college. The recovery college enabled patients to work with staff to teach other patients particular skills and activities. A skills analysis had been completed for staff and patients. The courses were due to start in April 2018 and included, basic life support, numeracy and literacy skills, hair and beauty and computer skills. The provider had a monthly planning meeting, attended by staff from across the hospital, including nurses, psychologists, medical staff and administrative staff. Patient representatives also attended. There was also a sub group, which comprised of patients from across the hospital who were developing the prospectus for the college and creating all the art work.

• Staff actively encouraged patients to attend multidisciplinary meetings and care program approach (CPA) meetings and participate in discussions about their care.

• Patients attended a variety of meetings within the hospital. Staff encouraged all patients to attend some meetings (e.g. 'community meetings' and ward 'clinical governance meetings'), whereas patient representatives were selected by patients to attend other meetings (e.g. the 'service user forum', the 'reducing restrictive practice' group and the 'food forum').

• A general advocate based at the hospital, regularly visited each ward to provide support to patients. Specialist mental health and mental capacity advocates each visited the hospital one day per week. They provided specialist support to patients upon request or referral.

• Patients were involved in the recruitment of all staff at every level. Patients spoke to us in a positive way about how important they felt their involvement was in securing appropriate staff and in developing their own confidence and skills.

• At the time of our inspection, staff had recently introduced a new system, whereby patients had the ability to nominate an element of service delivery to be audited. Following the audit, they were to be involved in the formulation of the audit report and resultant action plan.

• Patients had helped to make DVDs about the therapies provided at the hospital. Students and new patients watched the DVDs, in order to learn about the merits of the respective therapy programs.

• Staff told us that involving families and carers could be challenging, since the hospital accepted nationwide admissions and so some families lived a substantial distance from the hospital. The hospital had recently conducted an annual carer survey, although the results were not available at the time of this inspection. Staff had recently introduced a new satisfaction survey, which patients and carers completed at the point of discharge.

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

Good

Forensic inpatient/secure wards

Good

Access and discharge

• The hospital accepted nationwide referrals across England and Wales, from high secure hospitals; other medium and low secure hospitals; prisons; and community teams.

• The average bed occupancy level during the six-month period 16 April to 16 October 2017 was 95%.

• The average length of stay for current patients as at 16 October 2017 was 1,031 days. This was shortest on Eden ward, where the average length of stay was 284 days; and, longest on Irvine ward, where the average length of stay was 1,689 days.

• Patients moved between medium secure wards and low secure wards when clinically indicated and when beds were available.

• Staff supported patients when they were moving to another ward or preparing for discharge from the hospital. We saw evidence that staff completed extensive work to prepare and support the patient for their move, and to assist the staff at the new ward or service to ensure that the transition occurred as smoothly as possible. Patients we spoke with who had moved to another ward within the hospital, told us that they felt well prepared and supported prior to and following the transition.

• The hospital maintained patient placements during authorised periods of leave from the hospital. When a patient was potentially away for a longer period of time (for example, when held on remand in prison), staff liaised with commissioners to decide whether to preserve the patient's placement at the hospital.

• There were four delayed discharges during the six-month period 16 April to 16 October 2017. The main causes of delayed discharges were delays to the securing of ongoing funding and shortages in the availability of suitable ongoing accommodation within the patient's chosen area of the country.

• Staff worked with other agencies to ensure that appropriate aftercare services were in place for discharged patients.

The facilities promote recovery, comfort, dignity and confidentiality

• All wards had a clinic room and rooms where activities and therapy sessions took place.

• All wards had quiet areas and a room where patients could meet visitors.

• The communal areas within Avon, Berridale and Calder wards were noticeably cold on the first day of our inspection visit. We saw patients wearing outer garments within the ward communal areas. We highlighted this issue to the hospital director during our visit and they responded to resolve the issue.

• Patients had access to the hospital gym, which was equipped with cardiovascular conditioning and resistance training machines. A new fitness instructor had recently commenced working at the hospital. He had a number of ideas to develop a more extensive gym timetable and engage with patients to promote the benefits of physical exercise. There was also an outdoor sports pitch within the courtyard area of Chadwick Lodge. Patients told us how important this facility was to them and that they frequently used the area.

• Patients on the low secure wards had access to their own mobile telephones. Patients on the medium secure wards had access to the ward's cordless telephone to make private phone calls.

• Patients on all wards had access to outside space. Patients on the Chadwick Lodge wards had access to the courtyard, which had cultivated bedding areas and seating, along with the fenced, central sports pitch. Staff controlled patient access to the courtyard area according to individual risk assessment. Patient access to some of the garden areas on Eaglestone View was temporarily restricted, due to neighbouring construction work. However, patients from each Eaglestone View ward still had access to outside space during this period of time.

• Patients we spoke with gave mixed reports about the food provided. Some were happy with the quality and choice of food on offer, but others felt that the quality (in particular) was poor.

• Patients had access to snacks and beverages over a 24-hour period.

• Patients on the low secure wards were encouraged to participate in self-catering programmes, in order to build

their skills prior to discharge. Staff gave self-catering patients a weekly food budget and gave them the required level of assistance to go shopping and prepare their own meals.

• Patient representatives attended regular food forum group meetings, where they provided direct feedback on the quality and choice of food to hospital managers and catering staff.

• Patients had access to a lockable space to securely store their possessions. Patients on some wards had a locker in their bedroom, whereas lockers on other wards were centrally located in the ward communal area.

• Patients had access to their bedrooms at any time. Several patients showed us their rooms which were personalised and arranged as they wished. Most of the patients had electrical items in their bedrooms, such as a television and audio equipment. Where staff had assessed there was a risk posed for a patient (in relation to having electrical equipment in their bedroom), they took action to reduce the risk, for example by encasing the item in a protective cabinet.

• The occupational department organised the daily activity timetable for all wards. Occupational therapy staff facilitated activity sessions six days per week. Whilst ward staff participated in informal activities with patients, managers were working to increase the scope of meaningful activities they undertook, to augment the work of the occupational therapy department.

• Staff told us about the temporary loss of one activity room, which had been appropriated specifically for the delivery of therapeutic management of violence and aggression training. Some yoga sessions had been relocated due to the loss of the room. Managers told us that the room would be returned to the use of activities upon completion of the program of training.

• Occupational therapy was available on a full time basis across all wards and a variety of therapy sessions were also available on all wards. The occupational therapists operated a model which focussed on a holistic, person centred and recovery based approach. The occupational therapy led activity program was varied and recovery focused. However, some patients we spoke with told us they would like there to be more activities on offer.

• Staff organised individual and group outings for patients. Staff escorted patients to visit family or friends, where this was possible. Staff organised alternative day trips for patients who had no-one to visit.

• Patients had the opportunity to undertake voluntary work, appropriate to their ability and individually assessed level of risk. Some voluntary jobs took place within the hospital (for example, cleaning the gym or working in the hospital shop), whilst others where located within the local area. Some patients accessed education courses in the local area, accompanied by staff (in line with the patient's individual risk assessment).

Meeting the needs of all people who use the service

• The general internal environment within the hospital was suitable for people with restricted physical mobility.

• Patients with specific physical needs had necessary adjustments made to their bedroom and en suite toilet and shower facilities. However, there was no facility within the hospital to enable patients with restricted mobility to have a bath.

• Interpreters were available to patients as needed. We saw evidence that an interpreter had regularly accompanied a patient whose first language was not English to their care review meetings and ongoing therapy sessions.

• Psychologists adapted therapy sessions to suit the needs of patients with autistic spectrum disorder or a learning disability.

• A chaplain visited the hospital one day each week to provide multi-faith support to patients. The hospital had responded to the needs of patients with specific spiritual needs by working to secure ongoing visiting support services.

Listening to and learning from concerns and complaints

• Patients made a total of 17 complaints during the 12-month period October 2016 to September 2017. Nine were made by patients on Deveron ward. There was no common theme within the complaints made.

• Of the above 17 complaints, six were upheld and four were partially upheld. No complaints were referred to the ombudsmen.

Good

Forensic inpatient/secure wards

• The hospital received a total of nine compliments during the 10-month period December 2016 to September 2017.

• Staff discussed themes from complaints received during clinical governance meetings.

• Information boards within the wards displayed information about the complaints process.

• Information about the complaints process was also contained within the information handbook issued to new patients.

• One patient we spoke with had lodged a complaint several months ago, and was unhappy that they were still awaiting feedback on the outcome of it. We brought this to the provider's attention during our inspection visit.

• In August 2017, management had implemented a system of giving out a questionnaire at the time of sending the final response letter to a complaint. The aim of the survey was to obtain feedback on satisfaction with the complaints process. At the time of our inspection, the hospital had distributed eight questionnaires to complainants, but had not received any responses.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

• All wards had Elysium's organisational values clearly displayed within them. Staff had received leaflets and keyrings to further promote the organisation's values. Staff we spoke with were familiar with the values and in agreement with them.

• Managers and multidisciplinary team members we spoke with were familiar with senior managers and had regular contact with them. However, some nursing assistants we spoke with thought that senior managers had an insufficient level of presence on the wards.

Good governance

• Most staff had had an appraisal within the last 12 months and received regular supervision.

• Most staff had completed mandatory training relevant to their role.

• Staffing levels were sufficient to meet the needs of patients. Agency staff were rarely used, and where possible, bank workers were sent to wards with which they were familiar.

• Staff reported incidents appropriately and discussed learning points at team meetings. Staff gave information about incidents to patients at community meetings.

• Staff were open with patients when something had gone wrong.

• Ward managers had appropriate access to administrative support. They had sufficient authority to do their job and appropriate support from senior managers.

• Staff were able to raise concerns that where necessary could be fed into the hospital risk register. Staff discussed the risk register hospital clinical governance meetings.

• Staff had access to an electronic dashboard that clearly displayed important information for the running of each ward. Information displayed included statistics on recent incidents, staffing data, and details of patient risk assessments and care plans in need of review.

• The hospital had a comprehensive governance framework, which incorporated clinical governance meetings at ward, hospital, regional and corporate level. Senior staff met each morning to discuss events of the preceding day and ward teams also met every morning to discuss relevant issues and events. Staff and community meetings took place regularly on all wards and staff and patients alike had access to a number of forums where they could receive information and get feedback on recent incidents; ask questions or raise concerns, and provide suggestions. The governance structure also included the following monthly meetings: security meeting, reducing restrictive practice meeting, ward managers meeting, medical advisory committee meeting, learning from concerns and best practice meeting, health and safety meeting, and physical healthcare meeting.

• A member of the senior leadership team visited each ward on a monthly basis, to assess the experience of patients and staff. Clinical ward managers completed a monthly peer audit of a random selection of patient care records from a different ward.

Leadership, morale and staff engagement

• Results from the most recent staff survey were that: 1) 25% of staff respondents stated that they had insufficient

time to do their job well. Managers responded by remodelling shift patterns and introducing additional staff on each ward day and night; 2) 36% of staff respondents reported having experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. Managers responded by establishing links with a community and diversity officer for the police who met with patients and staff to highlight issues of harassment, discriminatory behaviour, racism and hate crime (during our visit, we saw evidence that black, Asian and minority ethnic (BAME) staff were subjected to regular verbal racial abuse by a small number of patients. BAME staff we spoke with told us they felt supported by managers and colleagues in this regard. We saw minutes of ward community meetings where patients had spoken out in their support of BAME staff and in aversion against racial abuse perpetrated by some of their peers; and 3) 26% of staff respondents reported that they did not believe that Elysium provided equal opportunities for career progression or promotion. Managers responded by working to increase the transparency of the recruitment and selection processes and reinforcing the level of human resources support to the hospital.

• The sickness rate for substantive staff during the 12-month period October 2016 to September 2017 was 4%.

• Staff we spoke with told us they felt able to raise concerns without fear of victimisation.

• Staff we spoke with knew how to use the whistle-blowing process.

• The hospital reported having a total of one bullying and harassment cases and three whistleblowing cases during the 12-month period November 2016 to October 2017.

• Most staff we spoke with exhibited a high level of morale and job satisfaction. They felt valued, empowered and supported by their managers. Additionally, most staff were highly positive about the organisational transition from the Priory Group to Elysium Healthcare. However, some nursing assistants we spoke with felt less engaged with the management structure and the process of change within the hospital. They reported feeling undervalued by managers.

• Staff at ward manager level and above had access to leadership and management training, delivered by an external provider. They also received training in fundamental human resources processes.

• Most staff we spoke with told us that they were part of a strongly cohesive and supportive team. Staff met regularly to discuss current issues and recent events. Each ward had a monthly reflective practice session and staff could give feedback in regular staff forum meetings.

Commitment to quality improvement and innovation

• The hospital has been an accredited member of the Royal College of Psychiatry quality network for forensic mental health services, for both medium and low secure services, since 2011.

• The hospital was working to obtain national accreditation for its dialectical behaviour therapy (DBT) program.

• Members of the psychology team recently organised a national conference on the therapeutic treatment of sex offenders. Approximately 80 delegates attended the event, representing a wide range of organisations such as high secure hospitals, national health service providers, third sector providers and commissioners.

• The hospital was planning to host a conference for forensic services (including the fire setting programme) during 2018.

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

• The ward presented some challenges for clear observation of the patients and staff managed this through individually risk assessed observation levels. A staff member was available at all times in the communal lounge area.

• The ward had a ligature risk assessment in place and identified risks were mitigated by, for example, mirrors placed in blind spots and enhanced patient observation. Staff we spoke with were aware of the location of ligature risks on the ward. However, we did find an area in the garden, which was a blind spot and this had not been identified on the ward risk register. The provider was informed about this during our inspection visit.

• The ward was for women only and complied fully with national guidance on same sex accommodation.

• The ward had a medicine dispensing room. Accessible resuscitation equipment and emergency medicines were available and checked regularly. The room was clean and tidy. The ward had access to a larger clinic room on the Eaglestone View site, with an examination couch where physical examinations could take place.

• There was no seclusion room on this ward.

• Whilst most of the ward was clean, the laundry room was visibly dirty with considerable amounts of unlabelled laundry strewn across the floor. The freezer in the kitchen was in need of defrosting and had milk in it which was out of date. The patients' fridge had spillage however, a patient told us she had recently cleared and cleaned the fridge so the spillage was new. The ward was due to move into a new purpose built building in the summer of 2018, however, we discussed with staff the need to maintain an acceptable level of cleanliness in the ward meanwhile.

• The ward had dedicated housekeeping staff. Cleaning records were complete and up to date. Cleaning schedules were available and followed.

• Environmental risk assessments were undertaken monthly and we saw evidence of work carried out as a result.

• Alarms were available in each room on ward and all staff carried alarms. We were told by all staff that alarms were responded to quickly.

Safe staffing

• There were no nursing or health care assistant vacancies on Hope House ward. Every day the shift ran with two qualified nurses and three health care assistants. Night shifts had one qualified nurse and three health care assistants. Temporary staff were used when patients required enhanced observation levels and the ward used agency and bank staff, who in the main were familiar with the service. The providers own staff covered a large number of the available shifts. The sickness rate was 4% and the staff turnover rate 9%.

• All staff told us there were sufficient staff to deliver care to a safe standard and whilst very busy, there were sufficient

staff on duty. We looked at the staffing rotas and there were sufficient staff on each shift. A member of staff was present in the lounge area at all times and patients said they received regular one to one time with their allocated nurse.

• There were sufficiently trained staff to carry out physical interventions. 91% of staff had received training in basic life support and 82% of staff had received training in intermediate life support. Hope House had a full time consultant psychiatrist and access to a visiting general practitioner (GP), as well as a physical health nurse specialist. Staff told us that they could always access a doctor if required, as both the psychiatrist and general practitioner were flexible and responsive to requests to attend the ward when required. The wider hospital provided psychiatric cover out of office hours, in an emergency and with holiday cover. GPs were accessed out of hours, using the local GPs' process and emergency services were contacted via 999 for any medical emergency.

• The ward manager told us that senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required.

• Staff told us it was usually possible to escort patients on leave at the particular time they required. Patients told us that leave was rarely cancelled. Staff kept cancellations of escorted leave to an absolute minimum and recorded any cancellations as incidents.

• The provider stated staff should receive mandatory training across 19 courses. The completion rates for Hope House staff were above 75% across all courses.

Assessing and managing risk to patients and staff

• There was no seclusion room facility at Hope House.

• There were 12 incidents of restraint, involving five patients, over a six month period preceding our inspection. Those patients liable to require restraint had a clear care plan describing this and the rationale behind this necessity. We looked at the records on restraint and saw that there was one incident of prone restraint which did not result in administration of rapid tranquilisation. Prone restraint is a face towards the floor position which should be avoided as it can compress a person's ribs and limits an individual's ability to expand their chest and breathe. Additionally, a person who is agitated and struggling needs extra oxygen and they are unlikely to get sufficient oxygen in the prone position.

• At the time of our inspection, there was one patient being looked after in long-term segregation (LTS). We looked at this patient's care plans and there was a clear rationale for the commencement of LTS, with evidence that it was necessary as a 'last resort' of managing disturbed behaviour. Detailed care plans were in place and focussed on what needed to be achieved to end LTS, by patients and by staff. Considerations had been made on how to nurse the patient in the least restrictive manner possible in the circumstances, including access to fresh air, occupational therapy input, activities and opportunities for human contact. The patient subject to LTS was awaiting transfer to a different hospital.

• We sampled six electronic care records on the ward, including some of those for patients detained under the Mental Health Act. The new electronic system had only been in place for a few months and staff were learning how to navigate the system. Staff used a nationally recognised electronic care record system, which included a risk assessment template and associated documentation. With one exception, staff had carried out comprehensive risk assessments for patients on their admission, taking into account historic risks, current risks and triggers which could increase risk. Patients, where they had wanted to and had consented to, had been actively involved in the risk assessment process. Reviews were undertaken during the weekly full multidisciplinary care reviews and following any incidents or safeguarding concerns. Staff also used the national framework of the care programme approach to assist risk management processes.

• Staff kept blanket restrictions at Hope House to a minimum. All patients had signed a contract or agreement which formed a formal acceptance into treatment. Part of this included a behaviour incentive programme. The behaviour incentive programme was developed collaboratively with patients and was based on the idea that rewards lead to an increase in treatment engagement. So for example, if the patients did not engage in identified problem behaviour they received rewards such as home leave, a group outing, free access to their bedroom or a reduction in observations. Staff supervised the main kitchen area on the ward at all times. Patients also had access at all times to hot and cold drinks in a communal and fully accessible part of the ward.

• Staff told us that, where they identified particular risks, they safely managed these by putting in place relevant

measures. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments we reviewed took account of patients' previous risk history as well as their current mental state.

• Patients told us, without exception that they felt safe at Hope House.

• We spoke with staff about protecting their patients from abuse. All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns they had. At the time of our inspection, 91% of staff had received training in safeguarding adults at risk and children and were aware of the organisation's safeguarding policy. In the last year two safeguarding concerns were raised, both currently closed.

• We checked the management of medicines on the ward and looked at nine medicine administration records. There were no errors. The medicines were stored securely on the ward. Daily checks were made of room and refrigerator temperatures to ensure that the medicines remained suitable for use. All medicines needed were available. We looked at the ordering system and saw the process for giving patients their regular medicines and we heard from patients about the information they were given. A pharmacist visited Hope House every week to check that policy and procedures were being followed correctly.

• Four patients were on a self-medicating programme. We looked at the care plans in the care records. The provider had a self-medication protocol and this was being followed. We spoke with two of the patients who were self-medicating and they were familiar with the protocol and confident in managing their medicine. Both patients spoke positively about the opportunity given to them to manage their own medicine in preparation for discharge into independent community living.

• Staff gave patients information about medicines. Staff discussed medicines in multidisciplinary care reviews. Staff discussed changes to the patients' medicines with them and provided leaflets with more information. We saw this happening during our inspection.

• Staff used clear protocols for patients to see children from their family. Each request was risk assessed thoroughly to ensure a visit was in the child's best interest. There was a meeting room available for visitors outside of the ward area.

Track record on safety

• The provider reported five serious incidents requiring investigation in the preceding 12 months. These included four incidents involving self-harm which necessitated transfer to an acute hospital for physical health care treatment and one incident of a patient not returning to the ward at the agreed time following home leave.

Reporting incidents and learning from when things go wrong

• All incidents were recorded on a new electronic system which had been implemented a few months before our inspection. Staff were confident in describing how the system worked. We reviewed three incidents and found in all cases the incident reports contained detailed information about what had happened. Clear follow up actions and lessons learnt were available and discussed in the ward clinical governance meeting.

• We tracked incidents back to patients' care records and in all cases patients had received a de-brief session following the incidents to immediately address any lessons to be learnt.

• Staff told us that they received feedback from investigations in regular team meetings and that they learnt key themes and lessons and developed action plans if they needed to make changes. Staff said there was always a debrief session arranged after a serious incident, and that a facilitated, reflective session would take place to ensure that staff felt adequately supported , in addition to learning lessons..

• The senior management team held a monthly 'learning out of concerns and good practice' meeting, scrutinising incident summaries for all wards and emerging themes. During team meetings, staff discussed learning from incidents. For example, how to safely manage risk and least restrictive practice and the importance of accurately recording leave arrangements.

Long stay/rehabilitation mental health wards for working age adults

Good

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

• Staff assessed patients' needs and delivered care in line with the patients' individual care plans. All patients received a thorough physical health assessment, and staff identified and managed risks to physical health. In addition to a psychiatrist working as part of the multidisciplinary team, a general practitioner visited the hospital site every week. A physical health nurse specialist was available on a full time basis and kept an overview of all patients' care plans with an identified risk associated with their physical health. All staff we spoke with were very confident in their ability to assess physical health care needs and provide robust care and treatment plans. The physical health nurse specialist told us that all patients received a complete physical health check on admission as well as regular reviews. We saw in the patients' care records that these checks had taken place.

• Care plans were personalised, holistic and recovery focused. The care plan process focussed on a patient's strengths and goals. This enabled a consistent approach during assessment, implementation and evaluation of patients' care and treatment. All of the patients' care plans had detailed plans to reduce risks associated with self-harm behaviour and the potential risk of poor communication between professionals.

• Patients told us that they received a copy of their care plans. Patients we spoke with told us that they were involved in the care planning process and that the plans were recovery focussed. There were many examples of staff applying this individualised approach to patients. The clinical meeting we attended discussed the patients as individuals with unique needs.

Best practice in treatment and care

• Staff used The National Institute for Health and Care Excellence guidance when prescribing medicines, in relation to options available for patients' care, their treatment and wellbeing and in assuring the highest standards of physical health care delivery.

• Each patient had received a detailed psychological assessment. Patients had access to a variety of psychological therapies which were all based on the dialectical behavioural therapy model as described as best practice in The National Institute for Health and Care Excellence guidance. This therapy was delivered either on a one to one basis or in a group setting, as part of the treatment programme and psychologists, occupational therapists, social workers and the nursing team had all been trained in dialectical behavioural therapy, were part of the multi-disciplinary team and were actively involved in providing the treatment.

• Staff on Hope House ward used a range of dialectical behavioural therapy as treatment for patients with a borderline personality disorder. The therapy included teaching cognitive behavioural techniques and mindfulness which helped patients to develop skills in order for them to be mindful, regulate their emotions, tolerate distress and to be interpersonally effective. Every patient attended at least two skills groups every week and a weekly individual session. Additional educational groups were available, for example a substance misuse group and trauma group.

• Occupational therapy assessment and outcome measures were in place for all patients.

• Staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These covered twelve health and social domains and enabled clinicians to build up a picture overtime of their patients' responses to interventions.

• Staff participated in clinical audits to monitor the effectiveness of services provided. All staff participated, at least weekly, in reflective practice sessions. They evaluated the effectiveness of their interventions.

Skilled staff to deliver care

• The staff on the ward came from various professional backgrounds, including medical, nursing, psychology, social work and occupational therapy.

Long stay/rehabilitation mental health wards for working age adults

Good

• Staff received appropriate training, supervision and professional development. Staff were encouraged to attend additional training courses. For example all staff had received training on working with patients with a personality disorder and a significant proportion of staff had received training in dialectical behavioural therapy.

• All staff we spoke to said they received individual and group supervision on a regular basis as well as an annual appraisal. Supervision was audited to ensure the experience was of a high quality. All staff participated in regular reflective practice sessions where they were able to reflect on their practice and incidents that had occurred on the wards. We noted that 92% of all staff had received an appraisal and 91% of staff were receiving regular supervision, both compliance figures were above the provider target. The revalidation of the medical staff was up to date.

• Senior managers told us they were not performance managing any staff for capability issues at the time of our inspection.

Multidisciplinary and inter-agency team work

• A fully integrated and well-staffed multidisciplinary team worked on the ward. Regular and fully inclusive team meetings took place. We observed a care review and found it to be highly effective, and saw the chair of the meeting involved the whole multidisciplinary team.

• Staff had space and time to feedback and add to discussions in meetings. Everyone's contribution was valued equally.

• We observed interagency working taking place, with primary care as a particularly positive example.

Adherence to the MHA and the MHA Code of Practice

• Out of 11 patients on the ward at the time of inspection, five were detained under the Mental Health Act.

• Over 92% of staff had received updated training on the Mental Health Act. Mental Health Act training was part of the mandatory training for staff including the revised Code of Practice.

• Care records were in order and easy to navigate. The Mental Health Act documentation was present and available.

• There was evidence in the care records to show that patients were regularly informed of their rights under section 132.

• There was active involvement of the independent mental health advocacy (IMHA) service and information about the service was displayed on the ward.

• Patients were encouraged to contact the Care Quality Commission if they chose to about issues relating to the Mental Health Act.

• The Mental Health Act administrator monitored requirements and compliance with the Act and Code of Practice, daily. Monthly audits were carried out on accuracy of T2 and T3 consent certificates, medicine charts and section 17 leave documentation.

• Copies of up-to-date section 17 leave forms were kept in a file accessible in the nurses' office. The forms were comprehensive, clearly detailing the levels, nature and conditions of leave. These were regularly reviewed and updated. There was good recording of who had been given copies of the section 17 leave forms. Copies of the section 17 leave forms were uploaded on the electronic patient record.

• Assessments of patients' capacity to consent to treatment were available, at the point that T2 certificates were issued and reviewed. T2 and T3 certificates were reviewed in line with the provider's policy.

Good practice in applying the Mental Capacity Act

• Over 93% of staff had undertaken Mental Capacity Act training. There was a Mental Capacity Act policy in place and staff told us about the principles and how they applied to their patients.

• Where a patient's health was deteriorating, the psychiatrist undertook frequent mental capacity assessments to ensure the person was capacious to consent or refuse treatments.

• No patients on the ward were being treated under the Mental Capacity Act. There were no current Deprivation of Liberty Safeguard applications and this was appropriate. (Deprivation of Liberty safeguards aim to make sure that people in hospitals are looked after in a way that does not inappropriately restrict their freedom).

Long stay/rehabilitation mental health wards for working age adults

Good

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

Good

Kindness, dignity, respect and support

• All of the patients we spoke with complimented staff providing the service throughout Hope House.

• Patients we spoke with told us that staff were busy, however, were generally available for them. Staff spent time with patients on and off the wards. Patients commented on the compassion and care shown to them by staff. Patients told us that staff were consistently respectful towards them. For example, several patients we spoke with told us that staff would always knock on their bedroom doors and wait for a response before entering. All of the patients said the staff could not do anymore to meet their needs and they worked hard and had patients' best interests and welfare always as their priority.

• Staff showed patience and gave encouragement when supporting patients. We observed this consistently throughout the inspection.

• Despite the complex, and at times challenging, needs of the patients using the service, the atmosphere throughout Hope House was very calm and relaxed. Staff were particularly calm and not rushed in their work so their time with patients was meaningful. Staff were able to spend time individually with patients, talking and listening to them. We did not hear any staff, on any of the wards ask a patient to wait for anything, after they approached staff.

• All staff we spoke with had an in-depth knowledge about their patients including their likes, dislikes and preferences. They were able to describe these to us confidently, for example, preferred routines for patients.

• We received many commendations by patients about individual staff throughout Hope House. Comments about them included them being particularly kind and perceptive.

The involvement of people in the care they receive

• Staff told us confidently about their approach to patients and the model of care practiced across Hope House. They spoke about enabling patients to complete the dialectical therapy programme, be as independent as possible and to return to living in the community in a less restrictive and non- clinical environment. Staff were non-judgemental towards their patients and empowered them to encourage their involvement.

• Patients received a comprehensive handbook on admission to the wards. The handbook welcomed patients and gave detailed information. This included information about health needs, the multidisciplinary team, care and treatment options, medicine and physical health needs, arrangements for health records and care plans.

• There was evidence of patient involvement in the care records we looked at and all patients had a copy of their care plans. Staff's approach was person centred, highly individualised and recovery orientated. We also saw that all patients reviewed their care plan at least once a week with the multidisciplinary care team and at least once each month with a member of the ward nursing team.

• At the time of our inspection, the provider was about to introduce a new electronic piece of software which encouraged significant patient involvement. The system enabled patients to write their own clinical record and also for them to rate their progress and see their care pathway in front of them. The system allowed for the multi-disciplinary team and the patient to generate an appropriate pathway and recommended therapeutically beneficial activities based on the information added by the team and patient. The software was connected to the electronic care records system allowing for this documentation to be added to the continuous written record.

• Local advocacy services were advertised and advocates regularly visited the ward.

• Staff discussed patients' views and wishes with them. During our inspection, we saw this happen in the multidisciplinary care review meeting we attended.

• Patients could get involved through a number of initiatives. The ward had a patient representative who sat on a number of hospital meetings. The representative encouraged patients to seek support and to be involved in their individual care and treatment planning and also in the wider service delivery. The provider had a patient audit group which enabled patients to choose an area for audit, develop the audit, collate the information and generate an

Long stay/rehabilitation mental health wards for working age adults

Good

action plan. The most recent audit completed was on primary nurse 1:1 sessions, looking at both quality and quantity of these sessions. The audit had been completed and an action plan was being generated by patients.

• Patients were involved in the recruitment process across the wider hospital including Hope House. Patients held panel interviews for key posts within the hospital. Patients received training prior to the interviews, to support them with the process and give them confidence to engage in the process.

• A patient forum attended by front line staff, patients and senior managers was held monthly. Each ward's nominated patient representative attended, including the representative from Hope House. Patients were encouraged to raise any issues that were affecting their community at this forum, as well as the hospital being able to share information with patients.

• Each ward, including Hope House had a monthly clinical governance meeting and the patient representative from the ward attended and was involved in discussions. Any relevant discussions were then discussed in the hospital wide clinical governance meeting.

• Chadwick Lodge was developing a recovery college. The recovery college enabled patients to work with staff to teach other patients particular skills and activities. A skills analysis had been completed for staff and patients. The courses were due to start in April 2018 and included, basic life support, numeracy and literacy skills, hair and beauty and computer skills. The provider had a monthly planning meeting, attended by all disciplines from across the hospital from nursing, psychology, medical and administrative staff. Patient representatives also attended. There was also a sub group, which comprised of patients from across the wider hospital who were developing the prospectus for the college and creating all the art work.

• Elysium Healthcare had an across organisational patient involvement meeting and the patient representative from Hope House attended. This group had recently overseen, planned and held a conference on the use of technology within mental health services. The conference was attended by all the hospitals across the organisation, patients, staff and representatives from commissioning groups from across the country.

• The head chef met with patients throughout Hope House to elicit feedback about the quality of the services and to hear feedback and suggestions for improvement from patients and ward staff.

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

Good

Access and discharge

• The average bed occupancy for Hope House was 96%.

• Hope house was a specialist dialectical behavioural therapy treatment service and as such patients could be placed there from across the country. Admissions were commissioned by Clinical Commissioning Groups. The average length of stay on the ward was 12-18 months. Patients were never moved to another ward in the hospital and there was always access to a bed when a patient returned from leave.

• The average waiting time from referral to assessment was 9-15 days and the wait from assessment to admission was between 27-37 days. At the time of our inspection four patients were on the waiting list for admission.

• There were two delayed discharges where assessments were taking place to transfer patients from the ward, one to a supported housing provider and one to a more secure hospital setting.

• Representatives from the multidisciplinary team assessed potential patients prior to admission and they told us that they were given sufficient time to complete the assessment.

• Patients spoke to us about their discharge plans and told us how staff were helping them to achieve these plans.

The facilities promote recovery, comfort, dignity and confidentiality

• The ward had a variety of rooms for patients to use including a quiet lounge, a therapy room and a communal lounge.

Long stay/rehabilitation mental health wards for working age adults

Good

• When physical examinations were required these were carried out in patients' bedrooms or in the physical healthcare clinic, off the ward area. All bedrooms were ensuite.

• The ward was somewhat restricted in space however a new purpose built ward was being built for the service to move into in summer 2018.

• Patients were able to make private phone calls and had access to their own mobile phones. Staff told us if patients needed to make a private phone call and had no mobile phone, they could use the office cordless phone for this purpose.

• The unit had access to a large garden with seating areas.

• Patient and staff feedback we received on the quality and range of food was generally positive. Snacks and beverages were available over a 24-hour period and patients had access to hot beverages.

• Patients were able to personalise their bedrooms according to the level they had reached on their behavioural incentive pathway, for example their photos and personal items on show. Patients had their own bedroom keys and they could access their bedrooms at any time. Patients were able to securely store all of their possessions in their bedrooms.

• Daily and weekly activities were advertised widely and available on Hope House. The activities were varied, recovery focussed and aimed to motivate patients. Staff provided activities in the evenings and across weekend periods. Examples of activities on the ward and at the main hospital site included healthy lifestyle sessions, exercise, cooking, music, arts and crafts.

Meeting the needs of all people who use the service

• Hope House was fully accessible for people with a disability including adapted toilet and bathroom.

• Staff told us that information could be made available in different languages as required by patients using the services. Information was available on interpreters.

• Local faith representatives from different religions were available within the local area to come in and see patients as desired.

• A choice of meals was available. A varied menu enabled patients with particular dietary needs connected to their religion and others with particular individual needs or preferences, to eat appropriate meals.

Listening to and learning from concerns and complaints

• There were four complaints in the 12 months preceding the inspection. The provider upheld three of these, which showed us that the provider was fair and transparent when dealing with complaints. Patients had written to the hospital director complimenting staff at Hope House for taking their complaints seriously and making changes as a result.

• Copies of the complaints process were on display in the communal lounge of Hope House and in the ward information file. Patients we spoke with all knew how to make a complaint. This included how to contact the Care Quality Commission should the patients wish to do so.

• Staff described the complaints process and how they would handle any complaints. Staff told us that they try to deal informally with concerns and to do this promptly in an attempt to provide a timely resolution to concerns. Informal complaints were tracked as well as formal complaints using the provider's electronic reporting system.

• Staff met regularly to discuss learning from complaints. This informed a programme of improvements and training, for example improving the induction process for temporary staff.

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

Good

Vision and values

• Elysium Healthcare took over the management of Chadwick Lodge and Eaglestone View hospitals, which includes Hope House, on 01 December 2016. In March 2017 Elysium Healthcare consulted with its patients, staff, management team and its board to identify their values. Through this consultation, the organisation's values were agreed as innovation, empowerment, collaboration,

compassion and integrity. These values underpinned a vision in which the organisation endeavoured to drive forward standards and outcomes of care in an ethical, open, honest and transparent fashion.

• The provider's vision, values and strategies for the service were evident and on display throughout Hope House. Staff on the wards understood the vision and direction of the organisation. Staff said they felt a part of the service and were able to discuss the philosophy of the ward confidently. Staff told us that the purpose of the ward was to offer patients a 12 month dialectical behavioural therapy programme to empower and enable patients to have aspirations and hopes in a safe and supportive environment. Patients would be able to develop a meaningful and quality future outside of a hospital setting, living in the community.

• The ward manager had daily contact with the unit manager and representatives of senior management were regularly visiting. The senior management and clinical team were highly visible and staff said that they regularly visited the wards every day.

Good governance

• Ward staff provided clinical quality audits, human resource management data and data on incidents and complaints. The information was summarised, updated daily and presented in a key performance indicator dashboard, called the 'in charge dashboard'. The ward had good access to robust governance systems, which enabled staff to monitor and manage the ward effectively and provide information to senior staff in the organisation and in a timely manner. One example of this was the dashboard scorecards which was updated daily and covered data including, quality compliance, incident analysis and trends, mandatory training compliance, staff sickness rates and complaints data for each ward. Incidents, care records and workforce data fed directly into the dashboard. Clinical information also fed directly into the dashboard and included data on patient demographics; legal status of patients; care programme reviews due and carried out; security and risk issues; care reviews due and last carried out; observation levels; escorting baseline risk assessment; room searches; section 17 leave; care plans; meaningful activity; physical health assessments; health of the nation outcomes; and, patient forecast discharge date and plan. Staff had successfully implemented three electronic systems over the last six months, including, care records, workforce support and incident reporting.

• We looked at the performance management framework and saw that data was collected regularly. This was presented in the monthly clinical governance meeting, across the hospital and in the Hope House clinical governance meetings. Where performance did not meet the expected standard, action plans were put in place. Managers could compare their performance with that of other wards through the scorecards and this provided a further incentive for improvement. There was evidence of Hope House meeting their key performance indicators and that the information provided was accessible and well-advertised.

• The senior management team undertook regular, "quality walk arounds" to Hope House. These were introduced to provide real time assurance of practices on the ward. This was part of a supportive framework to encourage high standards and quality improvement. Every month the senior management team met with patients and staff and audited the quality of the environment and the quality of staffing and their communication.

• The ward manager told us that they were encouraged by their manager to operate autonomously in managing their ward and received very good support from the lead nurses, the director of clinical services and the hospital director.

• The ward manager was familiar with and actively participated in the formulation of the ward and wider hospital risk register, which we viewed. The manager was able to articulate how the hospital risk register contributed to the Elysium Healthcare overarching risk register.

Leadership, morale and staff engagement

• Staff understood what was expected of them in their jobs, they felt supported by their line manager and felt they could safely raise concerns at work. They understood how their work helped to achieve the ward's service objectives. In the 'culture of care barometer', a staff survey, 70% of staff would recommend the hospital as a good place to work. However, most of the staff spoke negatively about a recent change made in their working hours. The change was made by the provider and meant staff taking a one hour and 47

minute break during their 12.5 hours shift. Staff said this break was too long, there was nowhere to take the break and a number of staff told us they had to spend the time sat in their cars.

• Hope House held regular team meetings and all staff described morale as good with their senior managers being highly visible, approachable and supportive. Topics recently covered included how to safely manage risk in the least restrictive approach.

• Sickness and absence rates were at 4%

• Staff said they felt very well supported in dealing with any concerns they had about any adverse behaviour from either fellow staff or patients.

• Staff were aware of the whistle blowing process. There was a policy, which the provider would follow for the investigation of concerns.

• Staff were able to confidently describe the importance of transparency and honesty and their duty of candour.

• All of the staff we spoke with expressed their pride in the strong element of team working across Hope House.

Commitment to quality improvement and innovation

• Staff participated in clinical audits to monitor the effectiveness of services provided. They evaluated the effectiveness of their interventions. Audits carried out included patient reported outcome measures.

Outstanding practice and areas for improvement

Outstanding practice

The psychology team operated a comprehensive, patient focused, individualised service. They adapted therapy sessions to suit the needs of patients with autistic spectrum disorder or a learning disability. Their dialectical behaviour therapy program had been specially adapted for use in forensic services, and it linked with the cognitive behavioural therapy and trauma work they also provided.

Psychology staff offered individual and group work to address offending behaviours and substance misuse. They also provided specialist treatment programs for male sex offenders and females with a history of fire setting.

Members of the psychology team recently organised a national conference on the therapeutic treatment of sex offenders.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve:

- The provider should ensure that the closed-circuit television cameras in the seclusion suite on Berridale ward are protected, to prevent removal by a patient.
- The provider should ensure that an appropriate temperature is maintained throughout the hospital.
- The provider should ensure that all staff groups receive supervision at a rate that conforms with hospital targets.
- The provider should ensure that all patients have access to appropriate dental care.
- The provider should ensure that all staff communicate clearly and effectively with patients.
- The provider should ensure that patients receive timely feedback on their complaints.
- The provider should ensure that the food provided to patients is of satisfactory quality.
- The provider should ensure that patients have access to a satisfactory amount and variety of activities.
- The provider should ensure that all patients have access to bathing facilities, as desired.
- The provider should work to ensure that all staff feel valued and engaged with senior managers.
- The provider should ensure the blind spot in the Hope House garden is risk assessed and adequately mitigated.
- The provider should ensure the Hope House laundry room and kitchen are kept clean.
- The provider should review the effect of the introduction of a one hour and 47 minute break on staff morale.