Waterloo Manor Independent Hospital

Quality Report

Waterloo Manor Independent Hospital
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Date of inspection visit: 27 - 29 June 2016
Date of publication: 25/08/2016

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?	Requires improvement
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.

Summary of findings

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

Overall summary

We rated Waterloo Manor Independent Hospital as good because:

Patient involvement within the hospital is well-embedded, with two staff involvement leads. Patients are involved at all levels within the hospital and attend Yorkshire and Humber regional involvement meetings.

Patients told us they were happy with the care they received at the hospital and spoke highly of staff. They said staff were respectful towards them and encouraged them to participate in activities. All patients were assessed by the occupational therapist, and had at least 25 hours of planned activity per week. This was reviewed weekly by staff at ward level.

Patients had access to well maintained outside space. On all of the ward areas, notice boards displayed information on involvement, activities and advocacy. Patients told us they valued the advocacy services which were available to both detained and informal patients.

Staff demonstrated a good understanding of safeguarding. Systems were in place to ensure that medicines were managed safely. Staffing levels across the hospital were adequate to meet the needs of the patients. The ward managers told us that they were able to increase staffing levels when there was an increase in the needs of the patients. Staffing levels were often maintained using bank and agency staff. Overall compliance with mandatory training was 93%.

Staff told us that blanket restrictions may be implemented for short periods of time but were reviewed. Staff showed a good understanding of the Mental Health Act code of practice and guiding principles. Mental Health Act and Mental Capacity Act principles were adhered to.

Prior to admission, each patient had an extensive multidisciplinary care plan developed, this identified patient needs, treatment options and goals. On admission, each patient was assessed, including a physical health examination. We found care records contained care plans which were person centred and showed evidence of involvement of the patient.

Menus showed a range of options were available for patients including vegetarian, healthy eating and halal diet. The chef attended weekly community meetings on the wards to keep up to date with any requests or queries from patients.

Staff told us that the culture at the hospital had changed in the last 12 months and they felt supported and valued. Staff survey results were positive. A 'lessons learnt' log was in place to review themes and trends of incidents. Complaints were investigated as per policy.

The provider had a specific policy for the duty of candour. The policy included an obligation to inform following a serious incident or near miss and included a specific undertaking for the service to apologise following incidents. Staff demonstrated an understanding of the principles of duty of candour.

However:

- Overall, wards were clean and the environment was well maintained. However, on Maple ward we found several areas that were unclean.
- Staff did not have training on how to meet the needs of patients with a diagnosis of personality disorder.
- Patients with bedroom windows which face the courtyard areas tended to keep their curtains closed to ensure that privacy and dignity are maintained.
- There were a number of blind spots in the hospital, such as bedrooms corridors, where action needed to be taken to mitigate this.
- There was limited provision of therapeutic groups within the hospital.
- Supervision and appraisal rates for staff were not consistent throughout the hospital.
- The hospital did not participate in national service accreditation or peer review schemes.

Summary of findings

Contents

Good

Waterloo Manor Independent Hospital

Services we looked at;

Forensic inpatient/secure wards and long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Waterloo Manor Independent Hospital

Waterloo Manor is an independent psychiatric hospital that provides assessments and treatments for women who have complex mental illnesses and associated needs. The hospital provides both low secure care and a rehabilitation service.

The hospital consists of three low secure wards: Cedar (12 beds), Maple (13 beds) and Larch (8 beds).Three locked rehabilitation wards: Beech (6 beds), Holly (4 beds), Hazel (8 beds). One open rehabilitation ward: Lilac (5 beds). The hospital has a total of 56 beds.

In August 2015 a focused follow up inspection was carried out and we found the service did not met all of the required standards. There was no registered manager in post and we identified a breach of Regulation 13 Safeguarding service users from abuse and improper treatment. At this inspection, we found the service was now meeting all of the required standards. The service now has a resistered manager.

Our inspection team

The inspection team consisted of five Care Quality Commission inspectors. A pharmacist advisor, an equality and diversity advisor, a Mental Health Act reviewer and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. This inspection was announced.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited six wards at the hospital; Cedar (12 beds), Maple (13 beds) and Larch (8 beds), Beech (6 beds), Hazel (8 beds) Lilac (5 beds), looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 10 patients who were using the service;
- spoke with the registered manager and managers or acting managers for each of the wards;
- spoke with the Mental Health Act administrator
- spoke with 22 other staff members; including doctors, nurses and health care support workers, occupational therapist, psychologist and social worker;
- spoke with an independent advocate;
- attended and observed two multidisciplinary meetings;

Summary of this inspection

- looked at 17 care and treatment records of patients;
- carried out a specific check of the medication management on two wards;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We gave all of the patients at the hospital the opportunity to speak with us. We spoke with 10 patients and the majority told us they were well looked after and cared for by staff who understood their needs. They told us staff were respectful and we saw that staff spoke to patients in a kind and caring manner.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- Overall, wards were clean and the environment was well maintained. However, on Maple ward we found several areas that were unclean.

However,

- Staffing levels across the hospital were adequate to meet the needs of the patients. The ward managers told us that they were able to increase staffing levels when there was an increase in the needs of the patients.
- Robust processes were in place to ensure the safe storage, administration, ordering and disposal of medicines.
- Staff told us that blanket restrictions may be implemented for short periods of time but were reviewed.
- The hospital governance team had implemented a 'Lessons Learnt Log'. This log detailed serious incidents by month, the lessons from each incident and the action taken by the hospital to reduce the likelihood of recurrence.

Are services effective?

Good

We rated effective as **good** because:

- Staff had not received training on how to meet the needs of patients with a diagnosis of personality disorder.
- There was limited provision of therapeutic groups within the hospital.

However,

- Prior to admission, each patient had an extensive multi-disciplinary care plan developed, this identified patient needs, treatment options and goals.
- Staff had received an annual appraisal of their work performance and received regular managerial supervision. Records showed staff had received supervision monthly in the previous 12 months.
- There was a system in place to check the competence of staff to administer medicines safely and carry out physical health checks on patients. Staff followed medicines management policies.

Summary of this inspection

- Staff showed a good understanding of the Mental Health Act, Code of Practice and guiding principles. Mental Health Act and Mental Capacity Act principles were adhered to.
- Patient records were complete and accurate.
- Staff had received training in safeguarding children.
- All patients were assessed by the occupational therapist, and had at least 25 hours of planned activity per week. This was reviewed weekly by staff at ward level.

Are services caring?

Good

We rated caring as **good** because:

- Patients told us staff were respectful towards them.
- Patients told us that staff were attentive and encouraged them to participate in activities.
- We found care records all contained care plans which were person centred and showed evidence of involvement of the patient.
- Notice boards located in patient areas displayed information on activities and advocacy. They also showed a number of opportunities for patients to work with the involvement lead on projects within the hospital.
- Patients have been supported by the involvement leads and clinical services manager to draft a comprehensive proposal for a hospital shop.
- Patient involvement within the hospital is well-embedded, with two staff involvement leads. Patients are involved at all levels within the hospital and attend Yorkshire and Humber regional involvement meetings.

Are services responsive?

Good

We rated responsive as **good** because:

- There was evidence of discharge planning in care records.
- Patients had access to a range of therapy rooms for occupational therapy assessments, gym facilities, salon facilities and a cinema room.
- All wards had excellent access to outside space. These were kept clean and well maintained by patients and staff at the hospital.
- Patients said they were happy with the food. Drinks and snacks are available 24 hours a day. On the rehabilitation wards, patients are able to make their own meals.

Summary of this inspection

- All patients have their own individual occupational therapy plans/activity calendars. These were personalised to the individual.

Are services well-led?

Good

We rated well-led as **good** because:

- The hospital had a local risk register in place. This was reviewed in the monthly Integrated Governance Committee meeting.
- The hospital had a whistleblowing policy in place. The policy was last reviewed in March 2016. The policy had the details of the provider's whistleblowing hotline. It was framed as a response to the recommendations of the Francis Report and included a commitment to respecting the confidentiality of whistle-blowers as well as the details of an independent organisation for whistleblowing and external contacts such as the Care Quality Commission.
- Staff survey results were positive and where actions were required, we saw plans were in place.
- The provider had a specific policy for the duty of candour. The policy included an obligation to inform following a serious incident or near miss and included a specific undertaking for the service to apologise following incidents. Staff demonstrated an understanding of the principles of duty of candour.

However,

- The hospital management team told us they did not participate in any national service accreditation or peer review schemes.

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.

All patients using the service were detained under the MHA. Staff showed a good understanding of the Mental Health Act, Code of Practice and guiding principles.

Mental Health Act and Mental Capacity Act training were covered in a single module which was considered mandatory. Compliance with this module was 84%.

We saw in care records that staff explained patient's rights to them every three months and recorded their assessment of the patient's understanding of the information on a form which was also signed by the patient.

We were told that when a patient was admitted, the senior Mental Health Act administrator would attend the ward to receive and scrutinise the patient's detention papers.

The staff told us that over the previous 12 months the hospital had developed a form for the responsible clinician to use to record their assessment of the patients' capacity to consent to their treatment. All of the patients' treatment was being authorised by an appropriate certificate.

Personal and room searches were sometimes performed but we were told it was only done when a need had been identified, which was confirmed in the care records we reviewed.

None of the current patients required their detention to be referred for review by the first-tier tribunal and the staff told us that they did not experience any administrative problems in making the arrangements for a tribunal. We saw care records contained a copy of the decision of each patients' last tribunal.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Health Act and Mental Capacity Act training were covered in a single module which was considered mandatory. Compliance with this module was 84%. Staff had an understanding and awareness of a capacity.

All care records had laminated Mental Health Act code of practice guiding principles and 'Record keeping' guide to remind staff of their responsibilities under the Mental Capacity Act.

The consent policy incorporated the Mental Capacity Act and provided guidance about the key principles of the Act and assessments of capacity. There was also a policy for the Deprivation of Liberty safeguards which are part to the Mental Capacity Act.

There were no patients subject to the Deprivation of Liberty Safeguards (DoLS), and no applications had been made in the last 12 months. Patients using the service were detained under the Mental Health Act.

Capacity to consent to specific issues, such as physical healthcare was routinely assessed and discussed in the multidisciplinary team meetings.

The hospital was meeting the requirements of the Mental Capacity Act.

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	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

The layout of the wards allowed for good lines of sight and observation. There were some blind spots, such as bedrooms corridors. Although mirrors were in place to mitigate this, there remained areas which were not visible. The registered manager told us they would take action to address this and the mirrors were ordered for installation as soon as possible. Access to bedrooms was not restricted during the day and patients had keys to their rooms where appropriate. Staff carried personal alarms which we saw and heard in use throughout our inspection.

We looked at the safety, suitability and cleanliness of all the wards. Overall, wards were clean and the environment was well maintained. However, on Maple ward we found several areas that were unclean. The toilet in some patients' bedrooms needed descaling. The communal bathroom on the ward had a sign on the door saying out of order for upgrading. However, staff told us it was still in use. The bath panel was unclean with debris around the edges. The toilet had a small amount of staining on it. One of the bedrooms had been temporarily occupied over the weekend and we found the shower curtain had extensive pink staining on it and dirty marks on the tiles around the shower. Staff told us there was always a deep clean after patients vacated bedrooms; however, it was evident that this had not happened prior to the patient occupying the room.

The patients' dining room furniture was clean on top surfaces, however, the legs of some tables and chairs were dirty as were the backs of some chairs. We found a small amount of debris under sofas and easy chairs. Whilst the floor was mainly clean, the edges around doorways had not been adequately cleaned. We found small areas of the servery were unclean, including, the shutter used when the servery was closed and the storage containers for tea, coffee and sugar were stained. We found out of date products in the occupational therapy skills kitchen fridge. We reviewed the cleaning schedule for the hospital and found instructions for cleaning staff were not detailed enough, however, staff told us cleaning schedules were being reviewed and would be more detailed in future.

We spoke with the registered manager about our concerns and staff rectified all of these issues prior to the end of our inspection.

Safe staffing

Staffing levels across the hospital were adequate to meet the needs of the patients. The ward managers told us that they were able to increase staffing levels when there was an increase in the needs of the patients. Staffing levels were often maintained using bank and agency staff. Efforts were made to try to use the same bank staff members regularly on the ward to maintain consistency. Agency staff were often 'block booked' by the hospital. This was also done to ensure consistency for the patients. Agency staff received an induction prior to working at the hospital and had completed the required mandatory training.

Total number of qualified nurses whole time equivalent: 18

Total number of nursing assistants whole time equivalent: 59

Whole time equivalent qualified nursing vacancies: 6

Whole time equivalent nursing assistant vacancies: 1

Good

Forensic inpatient/secure wards

Qualified nursing vacancy rate: 25%

Nursing assistant vacancy rate: 2%

Percentage of shifts covered by bank or agency: 21%.

Total staff establishment level: 144

Total number of substantive staff: 117

Total number of substantive staff leavers: 24

Percentage of staff leavers: 17%

Total percentage of vacancies overall: 15%

Total permanent staff sickness: 616 shifts

The registered manager told us recruitment was on-going to address all vacancies.

The hospital was able to produce data on the use of agency and bank staff to cover shifts. In the period June 2015 to May 2016 12% of shifts were covered by agency staff, and 9% of shifts were covered by bank staff. The highest use of agency staff was in February 2016, where 26% of shifts were covered by agency staff. The highest use of bank staff was in October 2015 where 16% of shifts were covered by bank staff. In total, the hospital covered on average 21% of shifts with either bank or agency and stated that this high use of bank and agency was partly the result of increased levels of observations. In the period October 2015 to March 2016 the hospital had a 18% rate of overtime worked as a percentage of total staffing.

We observed staff present and visible on all of the wards. Staff spent time in communal areas with patients. Staff told us they often helped out on other wards when patient need increased.

Average compliance with mandatory training was 93%. The hospital had 14 modules identified as mandatory or statutory training. These included manual handling, fire training, health & safety, security and infection control.

Assessing and managing risk to patients and staff

Staff at Waterloo Manor had completed a comprehensive ligature risk assessment. We saw some areas still presented a risk, however, these had been identified and we saw the ligature risk assessment stated that risks would be mitigated by individual risk assessment and observation levels. For example, communal lounge areas of the wards were supervised by staff at all times. Ligature cutters were kept in the main office.

Waterloo Manor was a smoke free environment and patients were unable to smoke anywhere in the grounds. Staff said random searches were carried out when patients returned from section 17 leave on a risk based approach to ensure patients were not bringing back any contraband items. Patients personal lighters are handed to reception and signed in and out daily by patients when accessing S17 leave, other contraband items would be removed and where appropriate returned when the patient is discharged from the hospital.

Staff told us that blanket restrictions may be implemented for short periods of time but were reviewed. For example, there had been a number of incidents which had taken place in the skills kitchen and the laundry. While the doors to the skills kitchen and the laundry were usually kept unlocked, these were locked at the time of our visit. Staff had put signs up informing patients of the temporary need for this. When we spoke with patients they told us they understood why this action had been taken and were supportive of staff keeping people safe. On all of the wards, doors to the lounges and the courtyard were kept open. Patients could access the internet at the occupational therapy department but the hospital was in the process of making the internet available to patients on the ward. Two tablet computers have been ordered and Wi-Fi was to be installed. Similarly mobile telephones without a camera or any means of recording had been ordered for patients to use while they are on the ward.

Robust processes were in place to ensure the safe storage, administration, ordering and disposal of medicines. Clinic rooms were clean and well ordered. Fridge and room temperatures were checked daily and were within recommended guidelines. The resuscitation bag and emergency drugs were stored in the office on each ward and checked daily to ensure the equipment was in good working order and the emergency drugs were in date.

Ward managers carried out weekly medication audits at ward level. These included auditing of stock levels. An independent pharmacy that supplied medicines to the hospital also completed a monthly audit.

A number of patients were on a self-medication programme and the staff had completed risk assessments in relation to this. Patients had care plans in place which provided staff with clear guidance on the administration of

Good

Forensic inpatient/secure wards

'as required' medication. Care records showed that monitoring of patients following administration of 'as required' medication was being completed as per care plan.

The hospital had two seclusion rooms. On Cedar ward we found this was suitable and fit for purpose, and had access to outside space. However, we found the door into the courtyard did not have a curtain which meant there was no way of darkening the room for sleeping during daylight hours. On Hazel ward, we found the door which accessed outside space was damaged and did not close properly. Senior staff looked at this and reported it to the maintenance team for repair as soon as we raised the issue.

From 1 October 2015 to 30 March 2016, there had been 31 incidents of seclusion within the hospital. In the same time period, there had been one incident of long term segregation. All of these occurred on Cedar ward. The use of seclusion was reviewed at the multidisciplinary meeting that took place each weekday morning.

Seclusion records were completed in accordance with the Mental Health Act code of practice. Patients in seclusion were routinely assessed and the need for continued seclusion reviewed. The records documented why the patient remained in seclusion, and the response to staff attempts to engage them.

From 1 October 2015 to 30 March 2016 there had been 227 restraints that involved 17 patients across all six wards. The most restraints were on Cedar ward (162) and Hazel (51). There were 10 prone or face down restraints across five wards, with most on Cedar ward (5) and 5 on both Hazel and Larch wards.

Track record on safety

The hospital reported one serious incident requiring external investigation in the last twelve months. The hospital uses an 'Accident and Incident Management Reporting Policy' to inform and support staff to report incidents. This report had a distinction between what constituted a serious incident, which required internal investigation, and a serious incident requiring investigation which is externally reportable.

There was a detailed safeguarding policy which included how to recognise different types of abuse and the action to take. This included the contact details of the local authority. Staff on the wards knew how to raise a safeguarding concern, and the hospital recorded and responded to these appropriately, and identified lessons learnt. We reviewed a sample of six safeguarding records. Most of these were patient-to-patient assaults and had been responded to appropriately. Referrals had been made to the local authority, and the necessary organisations informed. For example, the commissioners of the service and the Care Quality Commission.

Reporting incidents and learning from when things go wrong

In the period December 2015 to May 2016 hospital staff reported 517 incidents. At 286, Cedar ward had the highest number of incidents and Hazel ward had the second highest at 103 incidents. In the same period, hospital staff reported three incidents that were regarded as serious incidents. Cedar ward reported eight which was the highest number of serious incidents reported by one ward. These were appropriately investigated and responded to.

The hospital governance team had implemented a 'Lessons Learnt Log'. This log detailed serious incidents by month, the lessons from each incident and the action taken by the hospital to reduce the likelihood of recurrence. From April 2016, the minutes included an action log, which documented the progress of actions agreed in the meetings from February 2016 onwards. The log included a list of identified persons for each action and a traffic-light rating system, which rated the importance, and severity of each on-going action. This was then communicated through the hospital to staff via staff meetings and supervisions.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed ten care records across five different wards. Each patient had a comprehensive risk assessment and

care plan. All care records were in individual named files and were stored securely in each locked ward office. To aid consistency, all care records were indexed and followed the same format.

Prior to admission, each patient had an extensive multidisciplinary care plan developed, this identified patient needs, treatment options and goals. On admission, each patient was assessed, including a physical health examination. Risk assessment of the patient underpinned the care delivered. Each ward consistently used three different tools to assess and monitor on going risk. Health of the Nation Outcome Scale is used to look at a patients progress throught their care episode and a wide range of health and social domains; this is repeated every three months for each patient. Short term assessment of risk and treatability is completed every two weeks or updated following an incident; this identifies and measures strengths and vulnerabilities of each patient. A risk management plan for each patient provides a snapshot of current risk; this can be updated and reviewed daily. Each of the ten records reviewed included these three documents.

All the care records we reviewed showed evidence of physical health monitoring. In particular, long-term condition management for diabetes and asthma were evident. This information was captured in 'My Physical Health Record and Action Plan.' Other areas addressed included antipsychotic monitoring and high dose antipsychotic monitoring. Weekly monitoring of weight, temperature, pulse and blood pressure was also recorded.

There were comprehensive plans of care within the care records reviewed, with the focus being very much on recovery. The care records incorporated a standardised set of care plans addressing: 'managing my mental health recovery', 'stopping problem behaviour', 'getting insight', 'recovery from drugs and alcohol', 'making feasible plans for the future', 'staying healthy', 'my life skills', 'my relationships and my legal needs'. This approach demonstrated a person centred approach utilising the recognised Recovery Star tool.

Evidence of patient involvement in their care was consistently good. All care plans reviewed detailed the patients' perception of their needs, their own short and long-term goals and their responsibilities. The majority of care plans seen were signed by the patient, those that were not indicated a refusal to sign. In addition, care plan reviews included written patient comments and signatures.

Best practice in treatment and care

All of the care records we reviewed showed each patient was registered with a local GP. They demonstrated that staff utilised national clinical guidance for monitoring of diabetes. Furthermore, evidence of participation in national screening for cervical cancer was found, patients were given this opportunity through their GP. Other age specific screening programmes were identified on an NHS screening timeline. Each ward also had an identified physical healthcare champion.

The use of the Health of the Nation Outcome Scale and Recovery Star was evident in all care records reviewed. They were current and up to date. Evidence supported that these tools were used across the multi-disciplinary team on all five wards and informed clinical decision making.

Each patient also held their own individual 'Recovery File.' We saw copies of care plans and a 'My Health' document. This was completed by the patient and work covered: when I'm well, when I'm unwell, what affects my mental health, my behaviour and mental health, treatment in mental health, my disabilities, my physical health, where do I want to get to, goals, how do I get there and how can I tell how I'm doing.

The hospital offered a range of psychological therapies. These included dialectical behaviour therapy, cognitive behavioural therapy and offence work. There were vacancies for psychology assistants in the psychology team at the time of our inspection. There was one whole time equivalent psychologist, a post split between two staff members, for the whole hospital. At the time of the inspection occupancy levels were such that the psychology provision in place was determined to be adequate by the service. Psychological input for patients consisted of one to one sessional work or dialectical behaviour therapy group work. We were told there were no other therapeutic groups provided by the psychology staff available for patients to attend at the time of our visit.

All patients were assessed by the occupational therapist, and had at least 25 hours of planned activity per week. This was reviewed weekly by staff at ward level.

Good

Forensic inpatient/secure wards

Skilled staff to deliver care

There was a range of mental health professionals within the hospital, including psychiatrists, psychologists, social worker, occupational therapists, qualified nurses and involvement leads. The hospital had a number of patients across the wards that had a diagnosis of personality disorder. However, the hospital management team told us that none of the staff had received any training on how to care for patients with this diagnosis. We spoke with staff who worked across the wards and they all told us they felt patients would benefit from them having skills in this area. Patients we spoke with also told us they felt staff lacked skills in this area. The hospital management team told us they would ensure that this training was planned and delivered to staff following our inspection.

Figures taken from the integrated governance meeting minutes allowed average supervision rates to be calculated across the wards and other departments in the hospital. In the six-month period December 2015 to May 2016 the average supervision rate was 75.%. Larch ward was identified as having the lowest compliance with supervision with an average of 48% in the period December 2015 to May 2016. This was due to the absence of an established ward manager during that period. A ward manager was appointed and in post at the time of the inspection.

By May 2016 the average appraisal rate had reached 83%. Larch ward had the lowest appraisal rate, which by May 2016 was 42% and in the period December 2015 to May 2016 had averaged at 31%. Governance meeting minutes from June 2016 noted that Larch ward had the lowest appraisal rate and that a plan needed to be put in place to address this.

The hospital held staff meetings for senior healthcare workers, nurses, and at ward level. These meetings had started in April 2016 and June 2016 and it was not possible to form a judgement on the effectiveness of these meetings as they were still in their infancy.

Multi-disciplinary and inter-agency team work

A multidisciplinary team is composed of members of healthcare professionals with specialised skills and expertise. The members work together to make treatment recommendations to ensure quality patient care. The wards each followed a multidisciplinary approach to care and treatment. This involved nursing staff, a consultant psychiatrist, psychologist, social worker, occupational therapists and nurses. Multidisciplinary meetings were held on the wards every two weeks and staff worked together with patients to ensure they had the opportunity to attend meetings and discuss any concerns they had. Patient progress was reviewed at these meetings.

Multidisciplinary teamwork was well established. On a daily basis, a morning meeting was held to discuss the previous 24 hours activity within the hospital and share any immediate concerns/learning. A representative of each ward, psychology, occupational therapy, social work, psychiatry and senior management attended this. In addition, a clinical handover took place twice daily on each ward. This was documented electronically in the form a daily report.

Multidisciplinary reviews were planned in advance and the documentation supported patients to identify the needs they wished to discuss. We witnessed this during a weekly ward round, attended by the patient, named nurse, occupational therapist, psychologist and social work assistant.

Adherence to the MHA and the MHA Code of Practice

Staff showed a good understanding of the Mental Health Act, Code of Practice and guiding principles.

Mental Health Act and Mental Capacity Act training were covered in a single module which was considered mandatory. Compliance with this module was 84%.

We saw in care records that staff explained patient's rights to them every three months and recorded their assessment of the patient's understanding of the information on a form which was also signed by the patient. The hospital used both a standard information leaflet and an easy read version. All of the patients we spoke with had a very good understanding of their rights. However, one patient told us that they had only been informed of her rights once since their admission to the ward in January this year, which was confirmed in their care records. The charge nurse and later the hospital's senior Mental Health Act administrator explained to us that a rare administrative oversight had led to the electronic record not alerting the staff to remind the patient.

We were told that when a patient was admitted the senior Mental Health Act administrator would attend the ward to receive and scrutinise the patient's detention papers. In the

care records we reviewed, we found that the Mental Health Act documents were in a good order. The staff told us that over the previous 12 months the hospital had developed a form for the responsible clinician to use to record their assessment of the patients' capacity to consent to their treatment. We saw that the form was clearly set out and in addition to the four part capacity assessment the responsible clinician had recorded an account of their discussion with the patient, which included the information they had provided. A form was missing from the care record of one patient who was being treated under the authority of a T3 certificate and was completed immediately by the responsible clinician. A T3 certificate is put in place when a patient is unable to give consent for the medication their doctor has prescribed.

Personal and room searches were sometimes performed but we were told it was only done when a need had been identified, which was confirmed in the care records we reviewed.

None of the current patients required their detention to be referred for review by the first-tier tribunal and the staff told us that they did not experience any administrative problems in making the arrangements for a tribunal. We saw the care records contained a copy of the decision of each patients' last tribunal.

Good practice in applying the MCA

Mental Health Act and Mental Capacity Act training were covered in a single module which was considered mandatory. Compliance with this module was 84%. Staff had an understanding and awareness of a capacity.

All care records had laminated Mental Health Act code of practice guiding principles and 'Record keeping' guide to remind staff of their responsibilities under the Mental Capacity Act.

The consent policy incorporated the Mental Capacity Act and provided guidance about the key principles of the Act and assessments of capacity. There was also a policy for the Deprivation of Liberty safeguards which are part to the Mental Capacity Act.

There were no patients subject to the Deprivation of Liberty Safeguards (DoLS), and no applications had been made in the last 12 months. Patients using the service were detained under the Mental Health Act.

Capacity to consent to specific issues, such as physical healthcare was routinely assessed and discussed in the multidisciplinary team meetings.

The hospital was meeting the requirements of the Mental Capacity Act.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

We observed warm and engaging staff interactions with patients and heard staff speak to patients respectfully. Staff spent time with patients in communal areas. The atmosphere was calm and relaxed across the wards and we saw patients also spent time together and conversed with each other. Staff demonstrated a good understanding of patients and were able to describe the needs of the patients they cared for.

We offered all of the patients at the hospital the opportunity to speak to us. We spoke with 10 patients who, without exception, praised the staff team.

The involvement of people in the care they receive

Patients told us they received a service user guide prior to their admission so they knew what to expect when they were admitted to the hospital. In circumstances where this was not possible, one patient told us they were given the guide on admission and staff were able to answer their questions about visiting times.

Staff told us they encouraged patients to be as involved as possible in developing their care plans. We saw care plan reviews took place on a monthly basis but did not always show the involvement of the patient. Staff told us if this was not done then the patient would be asked at their multi-disciplinary team meeting if they had any issues with their care plans. This was recorded in two care records we looked at.

Advocates regularly attended the wards and held drop in sessions for patients. The advocacy service offered independent mental health advocacy for patients detained

Good

Forensic inpatient/secure wards

under the Mental Health Act and general advocacy support for informal patients. We saw the notice boards on the wards displayed the contact details and visit times of the advocates.

Every patient we spoke with said that they could contact the advocate directly and were very positive about the support the advocate provided. They particularly valued the advocate attending their fortnightly multidisciplinary team meeting to help them to communicate their point of view and the staff told us that the advocate represented the patients' views very robustly.

There were opportunities for patients to give feedback. Some of these methods included community meetings held on each ward and a service user involvement group which fed into the Yorkshire and Humber regional involvement group.

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Patients have been supported by the involvement leads and clinical services manager to draft a comprehensive proposal for a hospital shop. This is to support those patients who are unable to leave the hospital due to section 17 leave restrictions to purchase a range of items including toiletries, drinks, stationery items, confectionary and small gifts. The shop will be run by patients for patients and a business plan had been presented to the hospital management team, with a request for a small start-up loan and setting out the repayment terms. In principle, the team has agreed the proposal and patients are reviewing some of the details, including whether the shop is in a fixed area or is mobile, the range of items to be offered, whether a fridge may be required, storage area for stock etc.

Patients have been encouraged and supported to assist in the formulating a recruitment strategy for patient involvement in staff recruitment and retention, including the creation of specific questions and scenarios by patients. Patients will be involved in screening (with appropriate confidentiality considerations implemented) and patients fully involved in planning and undertaking interviews and making decisions.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

There were processes to consider and discuss referrals and admissions to the hospital. Access to and discharge differed from ward to ward. This depended on the reason for admission and their treatment needs and progress whilst at the hospital. The wards provided a range of care and treatment options to patients from a wide geographical area. The contract with NHS England meant they also accepted national referrals. All of the ward managers said they discharged patients during the day and would not accept admissions at night.

There were no delayed discharges in the 12 months prior to our inspection.

The pathway within the hospital was low secure to locked rehabilitation/recovery to open rehabilitation/recovery. The average length of stay for patients at the hospital was 25.9 months.

The facilities promote recovery, comfort, dignity and confidentiality

Some patient's bedrooms looked out over a central courtyard. Patients told us they tended to keep their bedroom curtains closed to protect their privacy and dignity as anybody using the courtyard would be able to see in.

There were various areas for patients to use. Including a quiet room which was also used as a de-escalation room. Patients had free access to outside space. There were various gardens including an area off the dining room

Good

Forensic inpatient/secure wards

which patients could use to take part in sporting activities. Some patients were very involved in gardening including the design of the outside space. In the garden area at the front of the building patients had used old car tyres as a display feature which were filled with plants. Areas which had just been decorated had signs on the walls saying 'I am a bare wall, please help dress me, all ideas welcomed'.

Patients had access to activities, for example 'social Friday', 'social weekend' which was run across the wards. Each ward had a patient involvement lead, we were shown the 'involvement folder' which contained information, minutes of community meetings, information about upcoming events and information about carers involvement. Community meetings were facilitated by the involvement leads and attended where possible by the hospital director and members of the multidisciplinary team. An events committee, involving patients and the involvement leads identifies activities for forthcoming holidays or other celebratory occasions. 'One voice' meetings were held monthly and facilitate patient representatives to raise and discuss issues that had arisen on their wards and plan for forthcoming activities.

Meeting the needs of all people who use the service

The service was accessible to people with disabilities and wheelchair users. A variety of information was on display across the wards. This included leaflets about wellbeing groups, therapies, healthy eating and advocacy services.

There was information about how to make a complaint on all wards. There was information advising detained patients of their right to make complaints in relation to their detention to the Care Quality Commission. Patients knew how to complain and had copies of complaints and compliments forms they could fill in.

There was a multi faith room on site that all patients and staff had access to. This was not a dedicated room and was also used for visits. Staff told us there were arrangements in place to access an interpreter service when required.

We looked at menus and saw a range of options available for patients including vegetarian, healthy eating and halal diet. The chef attended weekly community meetings on the wards to keep up to date with any requests or queries from patients.

Listening to and learning from concerns and complaints

There were 84 complaints made about the service between April 2015 and March 2016. The areas of complaints included, temperature on the ward area, security, staff, quality of care and section 17 leave. All of the complaints we reviewed had an outcome recorded. Of these, 27 were upheld. We saw an example of a complaint, investigation and response letter relating to a complaint that was not upheld. The letter to the complainant was comprehensive, apologetic and addressed all points of the complaint.

Patients told us they would speak with staff if they had any complaints to make. One patient told us they were supported by a member of staff to write a complaint.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

The hospital vision was:

- To improve and enhance mental and physical health and the wellbeing of everyone we serve through delivering services that match the best in the world.
- We exist to help people reach their individual potential, personal best and live well in their community.
- We aim to be the provider of choice for individuals with mental health needs, at every stage in their recovery journey.
- To achieve our vision we have a strong set of values.

The hospital's values were:

- Putting people first. We put the needs of our service users above all else.
- We are always respectful and honest, open and transparent, to build trust and act with integrity.
- We will constantly improve and aim to be outstanding so we can be relevant today and ready for tomorrow.
- We make a commitment to work in partnership so that services can be fully integrated to reflect the needs of service users, carers and communities.
- We enable choice and facilitate the involvement of patients in all aspects of their care and day-to-day life.
- We work directly with service users in the development of our services. Our service users added the following core values to the organisation:

- Growth
- Recovery
- Ownership
- Wellness
- Time
- Healing (& Home)
- Additionally – Hope, healing, faith, respect, support, happiness, help, willpower, family, belief.

There had been a period of change and restructure of management within the hospital. The registered manager was recent in post and the clinical services manager had only been in post for a few months. Ward managers said the service had started to feel more settled following the changes. The registered manager had further visions for the hospital which included encouraging and implementing ideas and providing staff with more responsibility and scope in their roles.

Good governance

Local clinical governance was reviewed in a monthly Integrated Governance Committee meeting. The meeting was chaired by the hospital director and included all the hospital's senior team and representatives of NHS England. The meeting included a review of incidents and serious incidents, restraint, seclusion and long-term segregation, safeguarding, complaints, compliments, statutory and mandatory training, supervision and appraisals, medication management, staff vacancies, feedback from external stakeholders (including Care Quality Commission), clinical effectiveness and service user involvement, service developments and any updates on the compliance action plan resulting from previous Care Quality Commission inspections.

We reviewed five months meeting minutes. The minutes included graphs plotting data on incidents, serious incidents, number of episodes of restraint and seclusion and number of service users involved, duration of restraints and seclusions. The minutes included commentary on data trends and discussion of actions resulting from trends in seclusion and restraint. From February 2016 the minutes included a 'Lessons Learnt Log'. This log detailed serious incidents by month, the lessons from each incident and the action taken by the hospital to reduce the likelihood of recurrence. From April 2016 the minutes included an action log, which documented the progress of actions agreed in the meetings from February 2016 onwards. The log included a list of identified persons for each action and a traffic-light rating system, which rated the importance, and severity of each ongoing action.

Clinical data from the local integrated governance meeting was also used as part of the provider level Corporate Integrated Governance Committee. Each quarter, Inmind produced a "Hospital Director Integrated Governance Report" which compiled all the data from the local Integrated Governance committees and compared it against the services. We reviewed the last two Corporate Integrated Governance Committee minutes which were a compilation of actions and commentary based on the Integrated Governance report. The detail for each hospital and the benchmarking commentary was included in the Integrated Governance report. The purpose of the report was to allow the hospital to 'emulate reporting by the NHS'.

The hospital rated clinical effectiveness by reviewing scores in the Health of the Nation Outcome Scale for secure settings, and for learning disabilities. The hospital monitored the number of new admissions who had one of these scales completed in the two weeks after admission compared with the total number of admissions In addition, the hospital monitored on a ward-by-ward level the total hours uptake of occupational therapy activities compared with the total hours offered.

The hospital had a local risk register in place. This was reviewed in the monthly Integrated Governance Committee meeting. There were six risks identified on the register. The provider had a higher level corporate risk register. There were seven risks identified on this register.

Average compliance with mandatory training was 93%. The hospital had 14 modules identified as mandatory or statutory training. Mental Health Act and Mental Capacity Act were covered in a single module which was considered mandatory. Compliance with this module was 84%.

Figures taken from the integrated governance meeting minutes allowed average supervision rates to be calculated across the wards and other departments in the hospital. In the six-month period December 2015 to May 2016 the average supervision rate was 75.%. Larch ward was identified as having the lowest compliance with supervision with an average of 48% in the period December 2015 to May 2016. This was due to the absence of an established ward manager during that period.

Good

Forensic inpatient/secure wards

By May 2016 the average appraisal rate had reached 83%. Larch ward had the lowest appraisal rate, which by May 2016 was 42% and in the period December 2015 to May 2016 had averaged at 31%. Governance meeting minutes from June 2016 noted that Larch ward had the lowest appraisal rate and that a plan needed to be put in place to address this.

In the period December 2015 to May 2016, hospital staff reported 517 incidents. At 286, Cedar ward had the highest number of incidents and Hazel ward had the second highest at 103 incidents. In the same period, hospital staff reported 14 incidents that were regarded as serious incidents. Cedar ward reported eight which was the highest number of serious incidents reported by one ward. The hospital uses an 'Accident and Incident Management Reporting Policy' to inform and support staff to report incidents. This report had a distinction between what constituted a serious incident that required internal investigation and a serious incident requiring investigation which is externally reportable. The hospital reported one serious incident requiring external investigation in the last twelve months.

The hospital had undertaken a full documentation audit in October 2015 and a self-assessment in February 2016, which looked at the five domains of Safe, Effective, Caring, Responsive and Well-Led. We reviewed the June 2016 audit of My Shared Pathway and associated care plans. This audited every patients care plan to check whether the plans included fully completed documentation within the 14 sections of the care plan identified as auditable. The audit concluded that there was an average of 75% compliance with the care plan audit standards. The audit identified that there were no recurring themes in errors in care plan documentation and feedback was given to each named nurse following the audit.

Governance minutes included a specific 'Lessons Learnt Log'. This log detailed incidents and key events by month, the lessons from each incident or event and the action taken by the hospital to reduce the likelihood of recurrence. Examples included, additional observation training and changes to care plans following the death of a patient, additional supernumerary time for staff to complete supervisions, and reiterations of policies following incidents during section 17 leave.

Leadership, morale and staff engagement

The hospital carried out a staff survey in April 2016 based on the Health and Safety Executive Management Standards approach to tackling work-related stress. The top three strengths are identified as staffs' understanding of their role, peers support and relationships, with actions to further improve including the introduction of a competency based framework, zero-tolerance forum and weekly reflective practice sessions. The three weakest areas were work demands, change and control. Actions to improve these areas for staff were highlighted as further consultation with staff regarding where they were working and area of choice, openness and transparency of managers/directors regarding changes in service provision staff having greater choice in where they work."

Staff told us, "We have moved forward massively in the last twelve months", "we are heading in a positive direction" and "it is very rewarding to see the patients move along the recovery pathway".

The hospital had a whistleblowing policy in place. The policy was last reviewed in March 2016. The policy had the details of the provider's whistleblowing hotline. It was framed as a response to the recommendations of the Francis Report and included a commitment to respecting the confidentiality of whistle-blowers as well as the details of an independent organisation for whistleblowing and external contacts such as the Care Quality Commission.

Staff at all levels said they would feel confident in speaking out if they had any concerns to raise. There was a policy for raising concerns at work which provided guidance for staff about different ways they were able to do this.

The provider had a specific policy for the duty of candour. In addition, the accident and incident management reporting policy which was reviewed in January 2016 included a commitment to the duty of candour. The policy included an obligation to inform following a serious incident or near miss and included a specific undertaking for the service to apologise following incidents. Staff demonstrated an understanding of the principles of duty of candour.

The hospital held staff meetings for senior healthcare workers, nurses, and at ward level. These meetings had started in April 2016 and June 2016 and it was not possible to form a judgement on the effectiveness of these meetings as they were still in their infancy.

Commitment to quality improvement and innovation

Good

Forensic inpatient/secure wards

Involvement within Waterloo manor was well-embedded, with two staff involvement leads. Patients are involved at all levels within the hospital and attend regional involvement meetings. Patients attend and participate in the whole of the monthly integrated governance meetings. Community meetings are facilitated by the involvement leads and attended where possible by the hospital director and members of the multidisciplinary team. An events committee, involving patients and the involvement leads identifies activities for forthcoming holidays or other celebratory occasions. One voice meetings are held monthly and facilitate patient representatives to raise and discuss issues that have arisen on their wards and plan for forthcoming activities.

The hospital management team told us they did not participate in any national service accreditation or peer review schemes.

Outstanding practice and areas for improvement

Outstanding practice

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Areas for improvement

Action the provider MUST take to improve

The provider must ensure the environment is clean.

Action the provider SHOULD take to improve

The provider should ensure that all staff who provide care and treatment for patients with a diagnosis of personality disorder receive training that enables them to meet the needs of the patients.

The provider should ensure that patients with bedroom windows which face the courtyard areas do not have to keep their curtains closed to ensure that privacy and dignity are maintained.

The provider should ensure that where there are blind spots in the hospital, such as bedrooms corridors, action is taken to mitigate this.

The provider should ensure that all patients within the hospital have access to psychological therapies.

The provider should ensure that supervision and appraisal rates for staff are consistent throughout the hospital.

The provider should ensure that they participate in national service accreditation or peer review schemes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment On Maple ward we found several areas that were unclean. The provider must ensure the environment is clean.