Kneesworth House

Quality Report

Kneesworth House Hospital
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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Inadequate
Are services responsive?	Good
Are services well-led?	Inadequate

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Edward Baker

Chief Inspector of Hospitals

Overall summary

We rated Kneesworth House as **inadequate** because:

- We had serious concerns about the forensic service, which consisted of Clopton, Ermine, Icknield and Orwell wards.
- The provider had not addressed all the breaches identified at the last inspection. When staff secluded patients, they did not do or record this in line with the provider's policy and the Mental Health Act Code of Practice. The provider had not prevented contraband items from entering some of the ward environments and had not resolved the ligature risks in the seclusion rooms. The provider had not fully addressed issues in relation to staff approaches towards patients.
- The provider had not kept patients safe from improper treatment and some staff were uncaring and disrespectful. Two patients told us some staff on Icknield ward used a key to prod their feet if they did not get up in the morning. Some patients altered their sleeping position or wore trainers in bed to prevent this happening. Seven patients we spoke with commented that a few staff were rude, unfriendly, did not listen to them or antagonised patients.
- Staff did not always complete risk assessments in a timely manner and did not manage patient risk robustly. Staff did not routinely update risk assessments after incidents. The provider did not have a consistent approach to physical health checks in line with guidance, including patients on high dose antipsychotics.
- Staff sometimes had to cancel patient leave and activities. Staff we spoke with told us that if there was an incident on the forensic wards, this could adversely affect plans for activities or leave. Four patients and one carer also told us there was insufficient staff to enable patients to take planned leave as planned and that staff regularly cancelled patient leave. On rehabilitation wards, six patients we spoke with told us that their regular permanent and bank staff were often moved to cover gaps in staffing on other wards, leading to a high use of agency staff.
- Staff did not consistently store, record or administer medicines in line with guidance. On forensic wards, staff did not always administer medication safely. Staff left syringes in pots of water with patient initials written on kitchen paper underneath. Staff had not recorded information about allergies on individual care records. Staff identified allergies to medicines on prescription charts, but these did not include full details of food allergies. On Clopton and Icknield wards, records did not contain a review for as-required medication in the previous 14 days. Staff audits did not ensure these issues were addressed.

Summary of findings

- The clinic room on Clopton ward was dirty and disorganised. The clinic room on Orwell was disorganised and the medicine cupboard on Icknield ward was broken. Some ward areas were dirty, and many areas were in need of repair and redecoration. This included stained and dirty toilets and unpleasant odours. Furniture was ripped and the system for ensuring maintenance jobs were completed was ineffective. The system to highlight, action and monitor maintenance issues across the wards was not robust.
- Staff did not consistently involve patients in care plans and risk assessments in the forensic service. Patient records did not document how patients were involved in care planning or risk assessments.
- Managers had not ensured that there were effective processes to inform them of poor practices in different parts of the service and could not therefore take immediate steps to address them.
- The provider had not addressed the challenges posed by the wards which were on two levels. In the forensic service, staffing levels were not sufficient to ensure that patients had access to the whole ward. Staff used restrictive practices to manage the ward environments on Ermine, Icknield and Orwell wards. Staff confined patients to upstairs or downstairs areas at certain times. On Icknield ward, patients had to be downstairs by 8.30am and in bed by 10.30pm.
- Electronic recording systems were slow, and staff experienced difficulties in accessing information quickly.

However:

- We did not have similar concerns about the acute ward and rehabilitation wards.
- The acute and rehabilitation services had sufficient nursing staff, who knew the patients and received basic training to maintain safe staffing levels. There were sufficient medical staff, including out-of-hours cover across the hospital.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. The provider supported staff with induction, appraisals, supervision and opportunities to update and further develop their skills. Managers monitored the performance of the team to ensure staff received appraisals, supervision and training.
- Staff completed comprehensive mental health assessments and assessed most patients' physical health fully on admission with a full medical assessment. Staff ensured that most patients had good access to physical healthcare and supported patients to live healthier lives, particularly on Bourn ward and in the rehabilitation wards.
- Staff held regular and effective multidisciplinary meetings. In the acute and rehabilitation services, staff treated patients with respect and put them at the heart of the discussion. They ensured that patients had access to independent advocates. Across the hospital, staff involved patients in their care through ward rounds and other multidisciplinary meetings.
- The rehabilitation and acute wards used systems and processes to safely prescribe, administer, record and store medicines in line with national guidance.
- The provider had emphasised the use of de-escalation in managing challenging behaviour. As a result, staff use of restraint had reduced since the last inspection.
- Staff provided a range of care and treatment interventions suitable for the patient group. This included medication, psychological therapies, ward activities and employment opportunities, such as the educational and vocational skill centre, which included a patient-run café.
- Staff informed and involved families and carers appropriately and enabled them to give feedback on the service they received. Carers we spoke with felt their relatives were safe and well cared for.
- Staff helped patients with communication, advocacy and cultural and spiritual support.
- In the acute and rehabilitation services, staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Summary of findings

- The service treated concerns and complaints seriously and investigated them promptly. Lessons learnt were shared with the whole team and the wider service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good 	Bourn ward
Forensic inpatient or secure wards	Inadequate 	Clopton ward, Ermine ward, Icknield ward and Orwell ward
Long stay or rehabilitation mental health wards for working-age adults	Good 	Nightingale ward, Wortham ward, Fairview, Swift House, Bungalows 63,65 and 67

Summary of findings

Contents

Inadequate

Kneesworth House

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient or secure wards; Long stay or rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Kneesworth House

Kneesworth House is part of the Priory Group of companies. It provides inpatient care for people with acute mental health problems, locked and open rehabilitation services, including some patients with a learning disability, and medium and low secure forensic services for people with enduring mental health problems, including some patients with a learning disability.

The Care Quality Commission last completed a comprehensive inspection of this location between 27 November and 1 December 2017. Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. Requirement notices were issues under the following regulations:

- Regulation 9 – Person-centred care
- Regulation 10 – Dignity and respect
- Regulation 12 – Safe care and treatment
- Regulation 17 – Good governance
- Regulation 18 – Staffing

The overall rating for this location was good, with requires improvement in the safe domain and good for effective, caring, responsive and well-led. The provider submitted action plans in relation to the breaches identified and had addressed some concerns identified at that inspection.

The service is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

The hospital had 140 beds. Since the last inspection, the provider had closed Wimpole ward, a 15-bed low secure service for women with a mental illness/personality disorder, in December 2018. A female psychiatric intensive care unit was planned but not open at the time of this inspection. The provider was also in the process of closing Icknield ward and looking to reconfigure their services at the time of this inspection.

We inspected the following core services:

Forensic inpatient/secure wards

- Clopton - 15 bed medium secure service for men with a personality disorder.
- Ermine - 19 bed medium secure service for men with a mental illness.
- Icknield - 16 bed medium secure service for men with a learning disability. This is due to close in June 2019.
- Orwell - 18 bed low secure service for men with a mental illness.

Long stay/rehabilitation wards for working age adults

Open settings:

- Bungalow 63 - four bed service for men with a mental illness.
- Bungalow 65 - four bed service for women with a mental illness.
- Bungalow 67 - four bed service for men with a mental illness.
- Swift - four bed service for men with a mental illness/ learning disability.

Locked settings:

- Nightingale ward - 17 bed service for men with a mental illness.
- Wortham ward - 17 bed service for men with a mental illness.
- Fairview - six bed service for women with a mental illness.

Acute wards for adults of working age:

- Bourn - 12 bed service for women.

Summary of this inspection

Our inspection team

The team that inspected the service comprised seven CQC inspectors, two CQC inspection managers, one Mental Health Act reviewer, one assistant inspector and a variety of specialists: three nurses, one occupational therapist, one social worker and one expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited twelve wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 42 patients and 11 carers of patients who were using the service;
- spoke with the registered manager and managers or acting managers for each of the wards;
- spoke with 48 other staff members; including doctors, nurses, occupational therapist, psychologist and social worker;
- received feedback about the service from two care co-ordinators or commissioners;
- spoke with an independent advocate;
- attended and observed four hand-over meetings and 10 multidisciplinary meetings;
- sought feedback from six patients at a focus group during the inspection;
- looked at 54 care and treatment records of patients;
- looked at 14 seclusion records;
- looked at 63 prescription charts, carried out a specific check of the medication management on all wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 42 patients, held one focus group and observed four community meetings. Patients told us that most staff were friendly, respectful, caring and helped them when they found things difficult. However, patients at a focus group on Icknield ward said that some staff did not speak English and often spoke to each other in their own language. Two patients said staff could be rude or unkind. Four patients said that staff spent too much time in the office and not enough time on the ward. Seven patients on the forensic wards said that a few staff were rude, unfriendly, did not listen to them and sometimes antagonised patients.

In the rehabilitation service, patients we spoke with said staff treated them well and behaved appropriately towards them. They told us they felt cared for, safe and could trust staff with their feelings. Patients felt that the

doctors listened to them, were professional and took their views into account during ward rounds. They told us that they knew how to complain if they were not happy about an aspect of their care, or had a concern, and staff supported them with this. Six patients we spoke with told us that their regular permanent and bank staff were often moved to cover gaps in staffing on other wards and this had an impact on their ability to build relationships with staff due to subsequent high use of agency staff.

Four patients in the forensic service said there were not enough staff. Staff sometimes cancelled activities and leave because of this. Patients in the rehabilitation service told us that they had regular access to occupational and psychological therapies which helped them with managing emotions, problem solving and daily living skills.

Patients felt that the doctors gave them the opportunity to talk about their treatment, listened to them, were professional and took their views into account during ward rounds. Patients said staff gave them copies of their care plan and discussed it with them. However, six patients on Icknield ward and one patient on Ermine ward said staff had not involved them in their care plan but wrote it for them.

Patients told us that there were ward rules on three wards about when they could be upstairs or downstairs which were for the benefit of the staff. Nine patients told us they did not like these rules and three of these said if they did not comply they could lose up to five days of leave.

We spoke with seven carers of patients detained on the forensic wards. Five said that communication was good, and six carers said that most staff were polite and treated them with respect. One carer of a patient on a forensic ward stated that the service was frequently short staffed and that their relative did not get out much despite being assessed as safe to do so. Three carers felt that their relative did not have enough to do, particularly in the evenings and at weekends.

We spoke with four carers of patients in rehabilitation services. Two carers felt that there were not enough activities, and staff should spend more time trying to motivate patients to engage and take part in activities even if they were reluctant to do this.

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?

Inadequate

We rated safe as **inadequate** because:

- We had serious concerns about the forensic service, which consisted of Clopton, Ermine, Icknield and Orwell wards.
- The provider did not ensure that equipment, including emergency equipment, was properly maintained and easily available. Staff did not consistently check emergency equipment after use and some equipment was not working. Nursing staff told us that some equipment, such as thermometers, were recording incorrect results and some physical health staff carried their own equipment because of this. There was a lack of signage on Ermine and Orwell wards in relation to emergency equipment.
- Staff did not consistently store, record or administer medicines in line with guidance. On forensic wards, staff did not always administer medication safely. Staff left syringes in pots of water with patient initials written on kitchen paper underneath. On Clopton and Icknield wards, records did not record a review for as-required medication in the previous 14 days. Staff audits did not ensure these issues were addressed.
- Staff had not recorded information about allergies on individual care records. These included potentially life-threatening allergies. Staff identified allergies to medicines on prescription charts, but these did not include full details of food allergies.
- The clinic room on Clopton ward was dirty and disorganised. The clinic room on Orwell was disorganised and the medicine cupboard on Icknield ward was broken. Some ward areas were dirty, and many areas were in need of repair and redecoration. This included stained and dirty toilets and unpleasant odours. Furniture was ripped and the system for ensuring maintenance jobs were completed was ineffective.
- Staff did not always complete risk assessments in a timely manner and did not manage patient risk robustly. We saw evidence in two sets of notes where patients had presented with historic risks, but staff had not identified and assessed their current risk. In the rehabilitation service, staff had not completed a HCR20 for one patient despite a history of violence, aggression or sexual offending towards others. Staff did not always update risk assessments immediately after incidents.

Summary of this inspection

- When staff secluded patients, they did not do this in line with the provider's policy and the Mental Health Act Code of Practice. Some medical and nursing reviews had not been completed within timescales, seclusion care plans were poorly recorded and in three examples of prolonged seclusion, did not make it clear why seclusion needed to continue. We saw evidence of a patient secluded for self-harming behaviour and staff failing to carry out multidisciplinary review recommendations.
- The provider did not have robust plans in place to seclude patients when necessary, or move them to quiet areas, should incidents occur in upstairs bedroom areas. Managers said they would manage this by using safety pods but these were very limited and needed to be shared across wards. The provider did not have an operational seclusion room on their acute ward.
- In the forensic service, staffing levels were not sufficient to ensure that patients had access to the whole ward. Staff used restrictive practices to manage the ward environments on Ermine, Icknield and Orwell wards. There were specific times when staff required patients to be upstairs and other times when patients were required to be downstairs. On Icknield ward, patients had to be downstairs by 8.30am and in bed by 10.30pm.
- Staff sometimes had to cancel patient leave and activities. Staff we spoke with told us that if there was an incident on the ward, this could adversely affect plans for activities or leave. Four patients and one carer also told us there was insufficient staff to enable patients to take leave as agreed and that staff regularly cancelled patient leave. On rehabilitation wards, six patients we spoke with told us that their regular permanent and bank staff were often moved to cover gaps in staffing on other wards, leading to a high use of agency staff.
- The provider had not effectively prevented contraband items from entering some of the ward environments. Cigarettes were in evidence on some acute wards, in particular Ermine ward, and searches had been ineffective.
- Staff access to clinical information was slow and unreliable. Staff had difficulty in accessing information quickly. Some agency staff could only access the system using a guest account which did not recognise who was inputting information. The hospital confirmed that there was a tracking system in place to manage this.

Summary of this inspection

- Staff did not consistently follow advice about resetting alarms on the wards. Staff gave conflicting information about the protocols for this during the inspection. There was a system in place for signing alarms in and out at reception as staff entered and left the unit.

However:

- We did not have similar concerns about the acute ward and rehabilitation wards.
- The acute and rehabilitation services had sufficient nursing staff, who knew the patients and received basic training to maintain safe staffing levels.
- There were sufficient medical staff, including out-of-hours cover across the hospital.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The provider had emphasised the use of de-escalation in managing challenging behaviour. As a result, staff use of restraint had reduced since the last inspection.
- On the acute and rehabilitation wards, the provider used systems and processes to safely prescribe, administer, record and store medicines in line with national guidance. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients and carers honest information and appropriate support.

Are services effective?

Good

We rated effective as **good** because:

- Staff completed comprehensive mental health assessments and assessed patients' physical health needs on admission with a full medical assessment. Staff developed care plans that met the needs identified during assessment.
- The provider had an extensive multidisciplinary team and provided a range of care and treatment interventions suitable for the patient groups. This included medication and a range of psychological therapies.
- Staff ensured that most patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff at the hospital had a full range of specialisms. These staff were experienced, qualified, and had the right skills and

Summary of this inspection

knowledge to meet the needs of the patient group. The provider supported staff with induction, appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- The ward teams had effective working relationships with other relevant teams within, and outside, the organisation. Staff engaged with these teams early in the patient's admission to plan discharge.
- Staff held regular and effective multidisciplinary meetings. Staff treated patients with respect and put them at the heart of the discussion.

However:

- Not all patients on high dose antipsychotic medication had received a regular electrocardiograph in line with national guidance.
- One staff member we spoke with told us they had not had an appraisal for over three years.
- One patient did not receive a physical health assessment until over two weeks after admission and one patient on Ermine ward did not receive appropriate health checks.

Are services caring?

Inadequate

We rated caring as **inadequate** because:

- We had serious concerns about the forensic service, which consisted of Clopton, Ermine, Icknield and Orwell wards.
- Not all staff respected patients' privacy and dignity. Patients on Icknield ward reported some staff used keys to prod their legs and feet to get them out of bed and that patients altered their sleeping position or wore trainers in bed to prevent this happening.
- Some staff in the forensic service were uncaring. Seven patients we spoke with commented that a few staff were rude, unfriendly and did not listen to them or antagonised patients. One patient said a member of staff had mocked them over a private issue. We also found an example of negative and judgemental language about a patient in a seclusion record. Patients on Icknield ward said that staff often spoke to each other in their own language, rather than in English.
- The provider used restrictive practices to manage the challenges posed by staffing numbers and environmental issues on Ermine, Icknield and Orwell wards. This included times for going to bed and getting up and times during the day when they had to be in their bedrooms.
- In the forensic service, staff did not consistently involve patients in care plans and risk assessments. Six patients on Icknield

ward told us staff wrote care plans and risk assessments for them and did not involve them. We reviewed 22 patient records. In 18 of these, documentation did not reflect that patients had been involved in their care plans and risk assessments or reflected that involvement was extremely limited.
- Patient records did not document how patients were involved in care planning or risk assessments and, in five records, staff had not evidenced and recorded patients' views well.
- Six patients we spoke with in the rehabilitation service, told us that their regular permanent and bank staff were often moved to cover gaps in staffing on other wards and this had an impact on their ability to build relationships with staff due to subsequent high use of agency staff.

However:

- The provider sought feedback from patients on the quality of care provided. They ensured that patients had access to independent advocates.
- Patients had some involvement in their care and treatment through ward rounds and other multidisciplinary meetings.
- Staff informed and involved families and carers appropriately. Staff enabled families and carers to give feedback on the service they received. The provider hosted a quarterly carers forum and an annual open day and lunch for carers. Carers we spoke with felt their relatives were safe and well cared for.
- Most staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients told us staff supported them to manage their own medication or to cook their own meals.

Are services responsive?

Good

We rated responsive as **good** because:

- Patients had their own bedrooms, could personalise them and had somewhere secure to store their possessions.
- There was a full range of rooms available at the hospital, including clinic rooms, the educational, and vocational skill centre, which included a patient-run café, and rooms suitable for therapy sessions. The hospital was set in spacious, pleasant grounds, so patients were able to access outside areas and take part in gardening and horticultural activities.
- The food was of a good quality. Most patients we spoke with told us they liked the food and they could make themselves hot and cold drinks and snacks outside of mealtimes when they wanted to. We observed bowls of fresh fruit available for patients on all the wards.

Summary of this inspection

- The provider worked effectively with commissioners to discharge patients. They liaised well with commissioners and external agencies that would provide aftercare and were assertive in managing care pathways for patients who were making a transition to other services. As a result, discharge was rarely delayed for other than clinical reasons.
- Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously and investigated them promptly. Lessons learnt were shared with the whole team and the wider service. When patients complained or raised concerns, they generally received feedback.

However:

- None of the patients' bedrooms had an en-suite bathroom or toilet. Patients had to share bathroom and shower facilities.
- Staff did not routinely record how they had responded to patient requests at community meetings on Ermine ward.
- The service could not meet the needs of patients with significant mobility issues.

Are services well-led?

Inadequate

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

- We had serious concerns about the forensic service, which consisted of Clopton, Ermine, Icknield and Orwell wards.
- The provider had not addressed all the concerns from the last inspection. These included not effectively preventing contraband items from entering some of the ward environments, not resolving the ligature risks in the seclusion rooms, not ensuring seclusion practices and recording met the standards in the Mental Health Act Code of Practice and not ensuring that all staff did not use punitive approaches or terminology with patients.
- Managers had not ensured that there were effective processes to inform them of poor practices in different parts of the service and could not therefore take immediate steps to address them.
- Managers had not ensured that there was an effective process in place to ensure that all clinic rooms were properly equipped and organised and that equipment was checked and maintained. We found numerous issues in relation to medication and the cleanliness of the environment, where staff had not rectified poor practices.

Summary of this inspection

- The provider had not addressed the challenges posed by the wards which were on two levels. The provider had not ensured that there was sufficient staffing to address the challenges caused by the layout of Ermine, Icknield and Orwell wards. This led to staff imposing restrictive and institutional rules on patients to compensate for the difficulties in staffing both tiers of these wards, leading to additional risks for staff and patients.
- In the forensic service, the provider had not ensured that all staff treated patients with dignity and respect. This included punitive approaches and terminology, institutional practices, such as rising and bedtimes, and periods when patients were confined to downstairs or upstairs areas.
- The provider had not consistently safeguarded all patients from abuse and institutional practices, for example in set rising and bed times and the way some patients were prodded with keys to get them up on Icknield ward.
- Managers had not ensured that staff kept clear maintenance logs and enabled staff to keep track of faults that had been reported. We found numerous issues in relation to medication and the cleanliness of the environment, where staff had not rectified poor practices.
- The provider's electronic systems were slow, and staff sometimes experienced difficulties in accessing information quickly.
- The provider had not ensured that staff consistently updated information for staff and patients on all wards, for example about advocacy services.

However:

- We did not have similar concerns about the acute ward and rehabilitation wards.
- In the acute and rehabilitation services, leaders had a good understanding of the services they managed. Leaders were visible in the service and approachable for patients and staff.
- Staff in the acute and rehabilitation services understood the provider's vision for the service. Most staff across the hospital were committed to provide high quality care for patients.
- Staff we spoke with felt respected, supported and valued. They reported that the provider promoted opportunities for career progression. Staff knew how to use the whistle-blowing process and told us that they felt confident to challenge colleagues if they observed poor practice without fear of retribution.

Summary of this inspection

- Managers accessed a dashboard to assess the performance of the team. This included information on supervision and appraisals and compliance with mandatory training. Managers used this to ensure staff were up to date with training and supervision.
- The provider had appointed an equality and diversity lead since the last inspection, to offer support to staff and take the lead on the equality and diversity strategy. Staff engaged actively in national quality improvement activities.
- There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Detailed findings from this inspection

Mental Health Act responsibilities

- Over 95% of staff received training in the Mental Health Act. Staff had a good understanding of the Mental Health Act and the guiding principles.
- Staff had easy access to administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice. Staff knew who their mental health act administrator was. The hospital had a mental health act administrator specifically for Bourn ward and all Mental Health Act paperwork was kept on the ward. Ward managers informed us there were good links with approved mental health professionals.
- The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. This was accessible to staff on the shared drive on the electronic system.
- Patients had easy access to information about independent mental health advocacy. We observed staff making referrals in a timely manner and advocacy staff attended Bourn ward during our inspection and met with a patient. However, there had been a recent change of provider and not all leaflets on the wards showed the current provider, particularly on forensic wards.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. However, we found one patient record where a patient had not understood their rights on admission and these had not been repeated nor had a formal capacity assessment been undertaken.
- Staff requested a second opinion appointed doctor when doctors had assessed that patients lacked capacity and kept forms T2 and T3 with patients' prescription charts. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate issued by a second opinion appointed doctor and is a form completed to record that a patient is not capable of understanding the treatment prescribed or has not consented to treatment but that the treatment is necessary and can therefore be provided without the patient's consent.
- Staff ensured patients were able to take Section 17 leave and completed and stored the paperwork appropriately. However, some patients were frustrated that they were unable to access Section 17 leave for a number of months after admission to the ward. Two patients' records did not contain information following their return from leave.
- The provider stored detention paperwork securely and staff had access to it when needed. The provider did regular audits to ensure they applied the Mental Health Act correctly. The provider completed the healthcare division Mental Health Act (MHA) audit in August 2018 for five patients per ward, who were detained under the Mental Health Act.
- On rehabilitation wards, staff displayed notices to tell informal patients that they could leave the ward freely.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Ninety-five per cent of staff had completed training in the Mental Capacity Act. Staff evidenced a good understanding of the principles of the Mental Capacity Act during this inspection. Staff training for Deprivation of Liberty Safeguards was at 93%. There were no applications made in the previous 12-months.
- The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it and knew where to get advice from within the provider regarding the Mental Capacity Act.

Detailed findings from this inspection

- Staff assumed patients had capacity to make decisions for themselves and assisted them to make decisions before assessing whether the patient lacked the mental capacity to do so.
- Staff assessed and recorded capacity to consent appropriately. This was on a decision-specific basis about significant decisions. There was evidence of this recorded on patients' care records.
- When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- The service had arrangements to monitor adherence to the Mental Capacity Act.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Forensic inpatient or secure wards	Inadequate	Good	Inadequate	Good	Inadequate	Inadequate
Long stay or rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Overall	Inadequate	Good	Inadequate	Good	Inadequate	Inadequate

Acute wards for adults of working age and psychiatric intensive care units

Good

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Good

Safe and clean environment

- Staff did regular risk assessments of the care environment. The fire risk assessment for the ward was in date and reviewed annually. We reviewed the action plan for this and most actions had been completed. Three actions remained; these had dates for completion and a responsible person identified.
- The ward layout meant there were blind spots. However, this was mitigated by convex mirrors throughout which allowed staff to observe all parts of ward.
- There were potential ligature points on the ward, but staff had mitigated the risks adequately through comprehensive ligature risk assessments, security checks and observations. The ligature risk assessments were available to all staff on the ward and were in date. A ligature point is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purpose of strangling themselves.
- Bourn ward was an all-female ward. Therefore, the ward complied with guidance on eliminating mixed-sex accommodation.
- Staff had easy access to alarms and radios. Patients had easy access to nurse call systems, these were in place in each bedroom on the ward. Patients had nurse call alarms in their bedrooms.
- All ward areas were clean, had good furnishings and were well-maintained. This had improved since the last inspection as the ward now had laminate flooring in all areas. One patient raised an issue to us around drains in the bathroom areas. Staff reported this to the estates department who addressed the issue during the inspection. The patient confirmed when these concerns were raised, the hospital did respond.
- Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. We observed domestic staff on the ward during our visit.
- Staff adhered to infection control principles, including handwashing.
- Managers had decommissioned the seclusion room on the ward. Access to this room was through the quiet area and met the guidelines of the Code of Practice. The manager stated there had been a period without any seclusions on the ward. Senior managers reviewed the use of seclusion and decided to decommission the room. However, seclusion figures had recently increased, and staff used seclusion to manage risk for two patients and recognised seclusion as the safest way to manage the presentation of these patients. Staff managed seclusions in the quiet area, rather than the former seclusion room.
- The clinic room was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. All equipment was calibrated, temperatures were checked and recorded daily and the room was organised and well laid out.
- Staff maintained equipment well and kept it clean. Any 'clean' stickers were visible and in date.

Acute wards for adults of working age and psychiatric intensive care units

Good

Safe staffing

- The ward manager informed us that the wards had vacancies. At the time of inspection, the overall vacancy rate for nursing staff and health care workers was 19%.
- Managers calculated shifts using a workforce plan in line with best practice and NHS safer staffing principles. Staff on Bourn ward worked long shifts with a two-hour break period. The day shift comprised of two registered nurses and two health care workers. Night shifts comprised of one registered nurse, two health care workers. In addition, the hospital had a floating health care worker to support areas when needed. Senior nurses met on a weekly basis to look at resources across the hospital. Shifts were filled by bank and agency staff for the week ahead and safe staffing levels were agreed twice per day for the day and night shifts.
- Data provided showed over a three-month period 201 shifts were filled by bank or agency staff. Managers used long term bank and agency staff to cover vacancies and periods of staff sickness. The data provided showed over a three-month period that 16 shifts were filled using bank staff but there had been one shift which was not filled to meet full staffing requirements that day.
- A qualified nurse was present on the wards at all times. Staffing allowed for one to one time with named nurses.
- Staff shortages were minimal and rarely resulted in staff cancelling escorted leave or ward activities.
- There was adequate medical cover day and night at the hospital. There was a doctor on call who had accommodation on site and could attend immediately. There was also a consultant on call who the doctor could contact for further advice. Staff contacted 999 in an emergency.
- Staff were up to date with mandatory training. Hospital training records showed overall staff in the service had undertaken 83% of training.

Assessing and managing risk to patients and staff

- We reviewed eight care and treatment records which showed staff did a risk assessment of every patient on admission and updated it regularly, including after an incident.
- Staff used recognised risk assessment tools on the ward which identified and responded to changing risks to, or posed by, patients. Staff documented this in patient care records and evidenced it at multidisciplinary team meetings.
- Staff followed good policies and procedures for the use of observation and for searching patients or their bedrooms.
- The ward had restricted garden access for patients detained under the Mental Health Act. The ward had timings displayed for patients. There were 22 opportunities from 08.00 to 22.45 for patients to be taken out to the garden. Informal patients were allowed access at any time. The system in place was to ensure staff could continue to deliver activities on the ward throughout the day.
- The ward had a sign displayed for informal patients at the exit of the ward explaining their right to leave. We spoke with one informal patient who stated she could leave at any time.
- There were no episodes of long-term segregation on the ward at the time of our inspection.
- There were 74 episodes of restraint in the previous six months up to January 2019. The episodes of restraint related to 27 individual patients. There had been a further 59 restraints since January 2019. There had been no prone restraints.
- The hospital delivered the prevention and management of violence and aggression training package to staff. This package does not teach the use of prone restraint as an approved method.
- All staff on the ward received training to carry out physical interventions, such as restraint and breakaway training. We observed, during our inspection, staff using de-escalation techniques to positive effect.
- The ward at the hospital participated in the provider's restrictive intervention reduction programme. The restraint training co-ordinator delivered physical intervention alongside positive behaviour support training. This training included the use of pods (bean bags specially designed for use during restraint).
- The provider had not reviewed the decision to decommission the seclusion room despite increases in seclusions. The seclusion room met the Code of Practice guidance.
- Staff used seclusion in relation to two patients. The needs of the patients were complex; all options were considered and seclusion was the agreed outcome best for the individuals. Staff accommodated this in the quiet area and documented as seclusion as the staff were a barrier to the patients leaving the room. However, staff did not lock or close the door to the area

as staff monitored the patient throughout. There were five incidents of seclusion between July 2018 and December 2018 on Bourn ward. Since January 2019, there had been seven seclusions of patients.

- One patient's period of seclusion was over a period of days. This was due to violence, aggression and infection control risks. Staff considered long term segregation at a senior management level as per the Code of Practice.
- We reviewed seven seclusion records. Staff kept appropriate records and adhered to timings of observations, nurse and doctor reviews and multidisciplinary meeting were held and recorded. However, two records had the wrong date recorded on them and one period of seclusion was missing a multidisciplinary review. The ward kept a running log of times for seclusion in addition to the seclusion paper record file. This meant staff could evidence the correct time and rectified this immediately. Staff recorded multidisciplinary meetings on the electronic system and placed a copy in the paper record.
- Staff were aware of and followed National Institute for Health and Care Excellence when using rapid tranquilisation.

Safeguarding

- Ninety three percent of eligible staff had received both safeguarding children and adults training. There had been six safeguarding referrals in the 12 months prior to inspection. Staff showed a good understanding of the safeguarding process.
- Staff followed safe procedures for children visiting the ward. There was a room provided for this on entry to the ward. Staff managed visit times in this area appropriately and made relevant checks before they agreed the visit.

Staff access to essential information

- All staff had access to the electronic system for patient records. Staff had no difficulty accessing or entering information including bank and agency staff.
- All information needed to deliver patient care was available to staff; this included agency staff.

Medicines management

- Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did so in line with national guidance.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence, especially when the patient was prescribed a high dose of antipsychotic medication.

Track record on safety

- Between January 2018 and December 2018, the ward reported three serious incidents. The nature of these incidents included a patient seen leaving the site and a patient found in a bedroom with open wounds requiring treatment.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. Staff explained how they reported incidents through the electronic system and through to senior managers on the hospital dashboard. The ward manager checked them to ensure they were detailed and actioned.
- Staff reported all incidents that they should report. Staff understood the duty of candour and told us the ward was open, transparent and gave patients and families a full explanation at the earliest opportunity if and when things went wrong.
- Staff received feedback from incidents, including investigation outcomes. This was achieved through debriefs, emails, multidisciplinary and monthly staff meetings. Staff met to discuss incidents and lessons learnt at six-weekly training sessions, known as TR6.
- There was evidence of change from feedback. For example, staff reviewed the transfer process between hospitals which included the handling of patients' belongings. Managers put a new handover process in place and informed staff about this.
- Managers debriefed staff following incidents. Staff we interviewed confirmed this.

Acute wards for adults of working age and psychiatric intensive care units

Good

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed eight care and treatment records. Staff completed comprehensive mental health assessments in a timely manner.
- Staff assessed patients' physical health needs on admission with a full medical assessment. This included when admitting patients during the night as the site's on- call doctor attended and completed this on the patient's arrival at the hospital.
- Staff developed care plans that met the needs identified during assessment. Care plans were personalised, holistic and recovery-oriented and were comprehensive. Staff updated care plans when necessary. Staff evidenced patient involvement throughout.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group as recommended by and delivered in line with, guidance from the National Institute for Health and Care Excellence. This included medication, psychological therapies such as mindfulness and one to one therapy. There were ward activities such as cooking, current affairs, music groups, ground walks and card making sessions. Weekend activities included trips to the community, ground walks and bingo. This had improved since the last inspection.
- Staff ensured that patients had good access to physical healthcare. This included access to specialists when needed, such as a dietician and speech and language therapist. Patients had regular physical health checks and observations. These were all recorded on the electronic record and review dates for each patient were recorded in the ward office to ensure these were met. The patients on the ward could also access a well woman clinic, held on a weekly basis.
- Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration.
- Staff supported patients to live healthier lives. For example, through participation in healthy eating advice and exercise sessions such as basketball with the occupational therapists.
- Staff used technology to support patients effectively. For example, electrocardiograph monitoring went straight to a central point and was analysed and returned to the hospital.
- Staff participated in clinical audit. The ward manager allocated these to staff, for example for infection prevention control and medical equipment.

Skilled staff to deliver care

- Staff at the hospital had access to the full range of specialists required to meet the needs of patients on the ward. This included doctors, nurses, psychologists, occupational therapists, access to a speech and language therapist and dietician on a referral basis.
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of the patient group.
- Managers provided new staff with appropriate induction (using the care certificate standards as the benchmark for healthcare assistants). Following this staff were orientated to the ward by way of a tour and spending one-day supernumerary on the ward.
- All staff had received supervision. Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) monthly and staff had group supervision opportunities. Managers reviewed staff appraisals annually.
- All staff had an appraisal in the previous 12 months prior to inspection.
- Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Two health care workers on the ward were undertaking nurse training, funded by the hospital. Managers gave time for attending university and placement. Staff on the ward had requested a course in phlebotomy and managers agreed this. The pharmacist had also attended and provided additional training for staff in medicines management.
- Managers told us they would deal with poor staff performance promptly and effectively. There were no concerns regarding staff on Bourn ward at the time of inspection.

Acute wards for adults of working age and psychiatric intensive care units

Good

Multidisciplinary and interagency team work

- Staff held regular and effective multidisciplinary meetings. We attended a multidisciplinary meeting on the ward, there were comprehensive discussions with the patients. Staff valued patients' views and made necessary changes to their treatment. There was evidence of active discharge planning as part of the agenda.
- Staff shared information about patients at effective handover meetings within the team. We attended morning handover on Bourn ward. This was comprehensive and included all areas of the patient care and their presentation. There were good examples of how well staff knew their patients.
- The team had effective communication, through handovers, with other relevant teams external to the organisation (for example, care co-ordinators, community mental health teams, and the crisis team). All patients had appointments and support arranged through the crisis team before the hospital would discharge them and care co-ordinators supported this.
- The ward team had effective working relationships with teams outside the organisation. For example, local authority, social services and advocacy. The hospital had a duty social worker available to patients daily.

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

- All staff received training in the Mental Health Act. Staff had a good understanding of the Mental Health Act and the guiding principles.
- Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their mental health act administrator was. The hospital had a mental health act administrator specifically for Bourn ward and all Mental Health Act paperwork was kept on the ward. The ward manager informed us there were good links with approved mental health professionals.
- The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. This was accessible to staff on the shared drive on the electronic system.
- Patients had easy access to information about independent mental health advocacy. We observed referrals being made in a timely manner and the advocacy staff attended the ward during our inspection and met with a patient.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand. They completed this quarterly and there were clear records to support this. Staff discussed this regularly with the patient at the multidisciplinary meetings.
- Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. We observed this during our visit.
- Staff requested an opinion from a second opinion appointed doctor when necessary. Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly on the electronic system and they were available to all staff that needed access to them. The service displayed a notice to tell informal patients that they could leave the ward freely.
- Staff did regular audits to ensure that the Mental Health Act was being applied correctly.

Good practice in applying the Mental Capacity Act

- All staff had completed training and were up to date with the Mental Capacity Act. Staff evidenced a good understanding of the principles of the Mental Capacity Act during this inspection.
- Staff training for Deprivation of Liberty Safeguards was at 93%. There were no applications made in the previous 12-months prior to inspection.
- The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it and were aware of how to get advice from within the provider regarding the Mental Capacity Act.
- Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to do so.
- For those patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. This was on a decision-specific basis with regard to significant decisions. There was evidence of this recorded on patients' care records.
- When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Acute wards for adults of working age and psychiatric intensive care units

Good

- The service had arrangements to monitor adherence to the Mental Capacity Act.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. We observed this on several occasions during our time on the ward.
- Staff directed patients to other services, such as a dentist or optician, when appropriate and supported them to access those services.
- Patients said staff treated them well and behaved appropriately towards them.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. There was a religious service on a weekly basis for patients; all denominations of faith could access a chaplaincy if required.
- Staff said they could raise any concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of any negative consequences.
- Staff maintained the confidentiality of information about patients. All patients had a form setting out their wishes about information sharing. These were up to date and stored on the ward for staff to access and refer to when needed.

Involvement in care

- Staff used the admission process to inform and orient patients to the ward and service. Staff also provided patients with an information booklet, which was informative and included the patient's named nurse.
- Staff involved patients in care planning and risk assessment. Staff evidenced this in care plans, participation in multidisciplinary team reviews, and patients had access to a copy of their care plan.
- Staff communicated with patients so that they understood their care and treatment. This included effective ways to communicate with patients who had difficulties. For example, on Bourn ward one patient who was unwell and at times chaotic, had a wipe board to map out thoughts. Staff were very aware of the patient needs and communicated plans for the day to reduce any anxieties the patient may have had.
- Staff involved patients when appropriate in decisions about the service. For example, patients attended staff induction to talk with new staff.
- Staff enabled patients to give feedback on the service they received. For example, via surveys or community meetings. The ward also had a suggestion box accessible to patients at all times.
- Staff ensured that patients could access advocacy. We spoke with the visiting advocate during inspection, referrals were timely and regular. The advocate was also attending the ward community meetings with patients.
- Staff informed and involved families and carers appropriately and provided them with support when needed. We observed this during our visit. For example, a telephone discussion held with the carer of a patient was thorough, and staff gave time to the individual. Staff made arrangements for a visit the following day. We saw evidence of the involvement of a family member for a patient who had a safeguarding concern and the family member was part of the decision-making process with the patient.
- Staff told us that carers could attend quarterly carer forum meetings and an annual carers day at the hospital, where they were encouraged to feedback their views. Staff asked carers for feedback as part of the peer review held at the hospital.

Acute wards for adults of working age and psychiatric intensive care units

Good

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- Average bed occupancy over the last 12 months prior to inspection was 81%. The average length of stay was five days for the ward.
- The ward accepted patients from out of the area. Patients were discharged to suitable placements near home if possible. The manager told us that the bed management team were supportive with this. Discharge planning took place from admission where aftercare services were regularly considered and documented. Patients were not moved between wards at the hospital during an admission episode unless it was justified on clinical grounds and was in the best interests of the patient. However, commissioners placed patients on Bourn ward for short periods of time and moved them back closer to their home area when possible.
- When patients were moved or discharged, this happened at an appropriate time of day. The ward manager told us due to the nature of the ward if a bed was available at night the bed would be offered to a patient waiting for admission if this was in the best interests of the patient. The hospital could meet all patient needs at this time if required; this included physical health as the on-call doctor was always on site.
- In the previous 12 months prior to inspection, there was one delayed discharge from the inpatient ward. This was due to a patient waiting for a place on one of the rehabilitation wards.
- Staff planned for patients' discharge, including good liaison with care managers and care co-ordinators. Staff told us that care co-ordinators attended meetings and those that could not attend used the teleconference facility.
- Staff supported patients during referrals and transfers between services. For example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. We saw evidence of this for one patient we reviewed.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. However, none of the patient bedrooms were en-suite so all patients had to share bathrooms and shower facilities. Patients personalised their room as they wanted. There were pictures on the wall, personal bedding and belongings such as photographs.
- Patients had a secure space to store their possessions.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care such as a well-equipped clinic room to examine patients, activity and therapy rooms.
- There were quiet areas on the ward and a room where patients could meet visitors.
- Patients could make a phone call in private, there was a public phone in a small private booth. Staff allowed patients to have their own mobile phones, to maintain consistent contact with families.
- Patients had access to outside space. Staff maintained and presented this area well. During our visit this area was regularly used by all patients on the ward.
- Patients could make hot drinks and snacks 24/7.

Patients' engagement with the wider community

- Staff supported patients to maintain contact with their families and carers. Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within other services and the wider community. Outside agencies visited the wards during our inspection and family members had contacted the ward and arranged to visit.

Meeting the needs of all people who use the service

- The ward was on the first-floor level where the only access was via the stairs. There were no lifts to the ward, therefore this would not be suitable for a physically disabled patient needing this level of adjustment. The hospital did not admit people with this level of need.
- Staff ensured that patients could obtain information on treatments, local services, patients' rights, how to complain and so on. There were notice boards on the ward with information for patients.

Acute wards for adults of working age and psychiatric intensive care units

Good

- The information provided was in a form accessible to the patient group. For example, in easy-read format if required. Staff made information leaflets available to patients.
- Managers ensured that staff and patients had easy access to interpreters and/or signers when needed.
- Patients had a choice of food to meet the dietary, religious or ethnic requirements. All the patients spoken with told us the food was nice, tasty and options were healthy, the food was freshly prepared, and arrived hot.
- Staff ensured that patients had access to appropriate spiritual support. A chaplain attended the ward on a weekly basis.

Listening to and learning from concerns and complaints

- The hospital had systems for the recording and management of complaints. When staff received a complaint, managers wrote to the complainant to acknowledge receipt and explained the process. We reviewed complaints, and staff responded to all within the required timescale.
- Between January 2018 and December 2018, there were three complaints. None were upheld but there was robust evidence to show thorough investigations of these complaints. The ward had received two formal complaints following patients' discharge, since January 2019. Staff were investigating both complaints at the time of our inspection.
- The ward had received 30 compliments in the previous 12 months prior to inspection, the highest amount across the hospital in that period. On the ward we viewed 39 cards displayed from families, patients and carers complimenting the team and staff on the ward for their care, kindness and professionalism.
- Patients knew how to complain and had the opportunity to raise complaints at monthly patient ward meetings. When patients complained or raised concerns, they received feedback from the hospital.
- The hospital employed a patient experience and improvement co-ordinator who supported the complaints process.
- Staff knew how to handle complaints appropriately. Staff received feedback on the outcome of investigations of complaints through meetings held bi-monthly, training on a six-weekly basis (TR6), supervision, ward meetings and hospital bulletins.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Leadership

- The ward manager had a good understanding of the service they managed. They could explain clearly how the team was working to provide high quality care.
- The manager was clearly visible on the ward and was approachable for patients and staff. We observed this many times during our visit. The service manager and senior managers visited the ward regularly. Staff interviewed spoke highly of the managers and the support they received. Staff informed us that the team on the ward worked well together and they enjoyed their role.
- Managers said leadership development opportunities were given to them within their role. This included requests to attend conferences and this was facilitated by the hospital.

Vision and strategy

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff applied these values to their work.
- Staff had the opportunity to contribute to discussions about the strategy for their service. One member of staff told us managers held meetings to give staff this opportunity.

Culture

- Staff felt respected, supported and valued by their managers. We observed a positive culture on the ward between the staff and managers during our visit.
- Staff told us there was a staff welfare lead who organised monthly events for staff such as team building. Staff said this made them feel valued.
- Staff were positive and felt confident to ask for support and felt able to raise concerns without fear of retribution.
- Staff knew how to use the whistle-blowing process, staff received training during induction and the policy was displayed in the ward office.

Acute wards for adults of working age and psychiatric intensive care units

Good

- Managers told us they dealt with poor staff performance when needed.
- The team on the ward worked well together, we observed this throughout our time on the ward. Managers dealt with staff appropriately when needed.
- Staff appraisals included conversations about career development and how managers could support this. For example, the provider was supporting two health care workers on the ward through nurse training.

Governance

- There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The ward manager told us there was an opportunity for a manager to sit in on the senior management team meetings and contribute to this.
- Managers held monthly lessons-learned meetings where they reviewed incidents. These included lessons learnt at a local (site) level and lessons from national partner organisations.
- Staff understood the arrangements for working with other teams, both within the provider and externally, such as care co-ordinators and community mental health teams to meet the needs of the patients.

Management of risk, issues and performance

- Ward managers were aware of the local risk register and said they could contribute to this. This was accessible on the shared drive on the electronic system.
- The hospital had plans for emergencies. For example, serious outbreak of infection and severe weather conditions.

Information management

- The hospital had an information management policy. The provider stored patients' confidential personal information securely. Staff had the technology required to carry out their role on the ward.
- The ward had effective systems in place for staff to report to external bodies. We saw evidence of this where staff had reported safeguarding concerns.

Engagement

- Staff, patients and carers had access to up to date information about the work of the hospital and services they used. For example, through meetings carers were invited to attend. The intranet had newsletters and bulletins and hard copies of these were supplied on the ward. Staff had an information board in the ward office informing them where staff could find these.
- The staff told us the organisation undertook surveys for patients and carers to give the opportunity for feedback on the service they received. For example, patient feedback had shown they feel safe at the hospital and they could talk to staff.
- Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. For example, following feedback from the carers' forum, carers helped to co-produce a carers awareness training package for staff.
- Directorate leaders engaged with external stakeholders, such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

- Staff had participated in a schizophrenia audit in the previous 12 months prior to inspection. The ward manager told us staff had participated in work around psychology.
- The hospital participated in the Quality Network for Forensic Mental Health in March 2018. The hospital had met 83% of the standards. The hospital was involved in annual peer review which the provider was conducting at the time of our inspection.

Inadequate

Forensic inpatient or secure wards

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

Are forensic inpatient or secure wards safe?

Inadequate

Safe and clean environment

- The wards all had blind spots and staff were not able to observe all areas of the ward. Staff adequately mitigated risk to patients through convex mirrors, closed-circuit television and staff observations. Ward layouts on Ermine, Icknield and Orwell wards were on two floors, with all the bedrooms on the upper floor. Clopton ward was on one level. Where wards had two floors, staff monitored both floors at various times of the day when patients were allowed to access the whole wards. There were also times when patients were required to access only one of the floors.
- Ligature risks were present on all the wards. A ligature point is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purpose of strangling themselves. Staff had access to an up-to-date, comprehensive electronic ligature audit for each ward which identified risks for each area and room. Staff had printed copies to refer to, but these were not the most up-to-date version. Staff mitigated risks through individual observations, risk assessments and regular security observations.
- All wards were single sex wards and complied with department of health guidance for the elimination of mixed sex accommodation.
- Staff carried alarms on all the wards. There was a system in place for signing alarms in and out at reception as staff entered and left the unit. Reception staff informed us ward staff should test alarms in the corridor outside the wards. However, staff did not apply this practice consistently. One staff member told us they only needed to reset alarms when they had gone off. This meant there was a danger that when staff requested assistance, their alarm did not transmit their location to responding staff. Patients had nurse call alarms in their bedrooms on Ermine and Orwell wards; on Clopton and Icknield wards, personal safety alarms were available to patients as appropriate.
- Not all areas of the wards were clean. Cleaners attended to most communal areas twice daily and, with consent, cleaned patients' bedrooms daily. On Icknield ward, the sink and toilets were dirty and stained with limescale deposits. There were gaps between the toilet base and the flooring where silicone sealant had begun to break down. There was also a storage room, containing discarded clothes, inside one of the toilets and wet rooms on Icknield ward where there was an extremely strong smell of damp and mould. We raised this with the provider during the inspection and staff took action to rectify this. There was also an unpleasant smell upstairs on Ermine and Orwell wards. We raised this with the provider at the end of the inspection who said they would take action to address this issue.
- The provider had not maintained all wards well. The décor across all the wards was tired and in need of attention. On Icknield ward, there were two damaged radiators and seven of the nine chairs in the communal area had cuts in the fabric. Staff told us patients damaged furniture with keys and that they replaced furniture regularly. Three chairs in the high dependency unit on Ermine ward had a number of cuts and cracks in the fabric. Staff removed these items but had returned one of the chairs to the room later in the inspection. On

Orwell ward patients had splashed drinks, floor to ceiling, in the stairwell area. Staff were not aware if a maintenance request had been made. There were also ripped chairs on Clopton ward. There were areas in need of redecoration and maintenance work, including damage to walls and furniture, on all the wards. There was a system in place to report damage and request repairs. On Ermine ward, we saw damage that staff had not reported. There was reference to urgent work requested in a patient's bedroom but no record of whether maintenance staff had completed the work.

- Handwashing gels were available on all the wards and staff adhered to infection control practices. Staff training compliance for infection control was 90%.
- There were seclusion rooms on all wards which complied with the Mental Health Act Code of Practice. All had observation windows, closed-circuit television and two-way communication. Seclusion rooms had toilet facilities and patients were able to see a clock. However, there was evidence of stains on the floors and ceiling in the seclusion room on Ermine ward and a toilet and sink were dirty. On Icknield ward, the sink and toilets were dirty and stained with limescale deposits and on Clopton wards the toilet and shower were dirty. The clock in one of the seclusion rooms on Ermine ward was faulty; the provider addressed this immediately when we raised this issue with them.
- Clinic rooms on Clopton, Ermine and Orwell contained a range of emergency resuscitation equipment and medicines. On Icknield ward, there was no emergency bag. Staff accessed the emergency bags on Ermine and Orwell wards when required. Staff told us they had requested this last year, but this had not been actioned. Managers told us they had conducted drills and could access the emergency bags on Ermine and Orwell wards within three minutes. A system was in place to ensure staff checked equipment regularly. On four occasions, records showed that staff had not completed checks on the emergency bag after they had used it. The oximeter on Icknield ward needed new batteries. On Ermine ward, staff had not sealed the emergency bag correctly. On Ermine and Orwell wards, there was no signage to indicate where emergency equipment was located.
- Clinic rooms on Ermine and Orwell wards were clean and tidy. However, on Orwell ward, the clinic room was not well organised. We found a drawer with an empty blood bottle labelled with patient details kept with a variety of other equipment such as scissors, tape and a stethoscope. On Icknield ward, the medicine cupboard was untidy and in need of internal repair. In the clinic room on Clopton ward, there was evidence of dust and cobwebs, there was a leakage on the floor from the electrical cooler and the space was untidy and disorganised.

Safe staffing

- The service told us that they had employed a workforce co-ordinator since January 2019 to review staff rotas and ensure vacancies were covered. The service also had daily staffing meetings to review sickness across the hospital. The service told us they had employed additional floating staff members and activity co-ordinators since our last inspection.
- The service had the basic numbers of nursing staff, who knew the patients and received mandatory training to keep patients safe from avoidable harm. However, when there was sickness or an incident, this could affect patients' leave or individual time with their nurse. The provider ensured there was adequate medical cover arrangements, including out of hours cover by two doctors based on site. Doctors attended the wards quickly when needed, for example, for emergencies or to undertake seclusion reviews. The provider employed seven consultant psychiatrists across the hospital and three specialty doctors.
- The provider reported that the service had 88 substantive nursing staff. This was highest on Ermine with 26 staff and lowest on Clopton with 18. Vacancy rates were highest on Ermine at 13% and lowest on Orwell at 1%. Twentynine members of staff had left the service in the previous 12 months prior to inspection. This was highest on Ermine with 11 and lowest on Orwell with three. Between 1 November 2018 and 31 January 2019, 105 shifts were filled by bank staff, 765 shifts were filled by agency workers and 14 shifts were not covered. Agency usage was highest on Ermine with 284 shifts and lowest on Orwell with 109. Staff sickness across the hospital during this period was 2%; the provider did not break this down to ward level.
- Managers had calculated numbers required on each shift and staffing levels on the wards reflected this. Managers told us they could adjust staffing levels according to need, when enhanced observations were required or when there were particular pressures on the

ward. Managers deployed bank and agency staff where required and left few shifts unfilled. Managers used workers who were familiar with the ward wherever possible.

- Staff we spoke with told us patients were generally able to spend regular one-to-one time with their named nurse and that they rarely cancelled this. However, five staff we spoke with told us that staffing levels did not always allow them to ensure patients received their leave and that the two-level structure of Ermine, Icknield and Orwell wards made it difficult to staff all parts of the ward effectively. Other staff we spoke with told us that generally, there were enough staff, but that if there was an incident on the ward, this could adversely affect plans for activities or leave. Four patients and one carer also told us there was insufficient staff to enable patients to take leave as agreed and that staff regularly cancelled patient leave. Managers monitored staffing at handover meetings and at the morning meeting, which covered the whole hospital.
- The provider had not ensured that staffing levels were sufficient to ensure that patients had access to the whole ward. Staff used restrictive practices to manage the challenges posed by staffing numbers and environmental issues on Ermine, Icknield and Orwell wards. These wards were on two levels, with bedrooms upstairs and communal areas downstairs. On Orwell and Ermine wards, there were blanket ward rules concerning access to bedroom areas. Staff required patients to be downstairs by 11:30 and in their bedrooms or upstairs communal areas prior to dinnertime. Managers told us this was to allow cleaners to clean patient bedrooms and staff to have 'protected time' periods to complete paperwork and administrative tasks. The provider had introduced a number of measures to manage this, for example, patients were asked to remain in their bedrooms and some communal areas upstairs at certain times. There were also set times for patients to get up in the morning on Ermine, Icknield and Orwell wards, and on Icknield ward the timetable in the communal area stated that all patients should be up by 8.30am and go to bed at 22:30. The provider stated this was to allow the cleaners to clean patient bedrooms. Nine patients we spoke with told us they did not like this arrangement. Three patients, of the 18 we interviewed, told us that failure to comply with this rule could mean that staff cancelled their leave for up to five days. Staff confirmed that failure to comply with ward rules would mean patients lost their leave but said this was just for that day. We raised this with the provider during the inspection, who removed restrictions to bedroom access on Orwell and Icknield wards.
- Nurses and support workers monitored patient areas. The wards allocated a security nurse to ensure staff checked all areas regularly. Where staff identified additional risks, they mitigated these by enhanced observations.
- Staff received training in physical interventions and there were sufficient staff to carry these out when needed.
- The provider did not break down mandatory training compliance to ward level. Across the hospital, staff compliance in 16 of the 17 mandatory training courses was 90% or over and in four courses, compliance was over 95%. The lowest compliance rate was 75% for basic life support with defibrillator.

Assessing and managing risk to patients and staff

- Staff used a range of different risk assessment tools and updated them regularly. These included the short-term assessment of risk and treatability (START) and the historical, clinical, risk management tool (HCR20). We reviewed 22 patient records. Where staff assessed patients to be a risk to others, they completed a HCR20 risk assessment tool to provide further detail about how they would manage this risk. However, staff did not always complete detailed risk assessments for all patients in a timely manner. Staff had not completed a risk screening for one newly admitted patient for 24 days.
- Staff updated risk assessments at regular intervals, and recorded, in detail, incidents that had occurred since the last review in the updated assessment. Staff discussed risk at ward rounds, handovers and the morning meetings. Staff maintained hourly security checks of all areas of the ward and were aware of ligature points and poor lines of sight. Where necessary, staff mitigated risk by enhanced observations. However, staff did not always update risk assessments immediately after incidents.
- When staff secluded patients, they did not always do this in line with the Mental Health Act Code of Practice and the provider's policy. Between 1 July 2018 and 1 January 2019, there were 36 episodes of seclusion and one episode of long-term seclusion across Clopton,

Ermine, Icknield and Orwell wards. There were 14 on Icknield, 13 on Ermine, five on Clopton and four on Orwell. In addition, there were seven on Wimpole ward between 1 July 2018 and 20 December, when it closed. We looked at 14 seclusion records across four wards, including three examples of prolonged seclusion. There were two occasions where a doctor did not attend within the first hour after the patient was secluded. Doctors did not always carry out medical reviews prior to an initial multidisciplinary team review. The information within seclusion policies and forms contained conflicting information about the makeup of the multidisciplinary team required for reviews of seclusion. This meant that staff did not have clear information about the requirements for the reviews. On two occasions a senior manager was not present and, on another occasion, only one clinician was present, where the provider's policy stated there should be two. There were three occasions where nursing reviews were not completed within the correct timescales and two occasions where two nurses were not present for the review. Staff secluded a patient on Clopton ward for self-harming behaviour, contrary to the Code of Practice. Only one of the 14 records we reviewed indicated what the patient took into the seclusion room with them. Staff completed seclusion care plans poorly in 13 of the 14 records reviewed and in two examples of prolonged seclusion, observation notes were missing. In three instances, observation notes did not evidence the need for seclusion to continue. In one of these, staff did not follow the multidisciplinary team recommendation to maintain separate food and fluid charts and used negative and judgemental language about the patient.

- Staff received training in physical interventions. Across the hospital, mandatory training compliance was 90%. The provider had recently started to teach different techniques, which did not include training to restrain patients in a supine (face-up) or prone (face-down) position. Staff received training to disengage if patients put themselves in this position and re-engage only when they had resumed a standing position. Staff also received training in the use of 'safety pods'; these were similar to bean bags and designed to restrict movement and reduce injuries to patients. However, not all wards had these at the time of inspection. Some staff we spoke with said they did not feel adequately prepared to support patients who harmed themselves when on the floor. Staff training emphasised the need to use de-escalation techniques and use physical interventions as a last resort.
- The provider had worked to reduce the numbers of physical interventions with patients. Compared to the last inspection, restraints for this service had reduced by 38%. Between 1 July 2018 and 1 January 2019, there were 108 incidents involving physical interventions, across the four wards. During this period there was no use of rapid tranquilisation. There were also 65 incidents on Wimpole ward from1 July 2018 and 20 December, when it closed. In one incident, staff placed a patient in a prone (face down) position on Wimpole ward, to administer intramuscular medication.
- Staff responded to varying levels of risk and adjusted risk assessments at regular intervals. Staff discussed risk at ward rounds, handovers and the morning meetings. Staff maintained hourly security checks of all areas of the ward and were aware of ligature points and poor lines of sight. Where necessary, staff mitigated risk by enhanced observations.
- The provider used a number of blanket restrictions and contraband rules appropriate to a secure setting. The provider had systems in place to prevent contraband entering the ward. However, on Ermine ward and to a lesser extent on the other wards, these arrangements were ineffective. Staff continued to find evidence of cigarettes in patients' bedrooms despite efforts to exclude them from the ward.
- We observed staff getting patients up on Icknield ward at 8am. Two patients told us some staff prodded patients' feet and legs with a key if they were reluctant to get up. Patients had not raised this with staff or managers, but some had started to sleep with trainers on or change their sleeping position to stop this from happening. We raised this with the provider during the inspection and they took immediate action. The provider investigated and took action against one staff member.
- Staff searched patients randomly when returning to the ward after leave. However, on Ermine ward the 'randomiser' did not work correctly; we tested it on eight occasions and each time it told staff to conduct a search. Staff also searched bedrooms for contraband items, including tobacco. On Ermine ward, there had been occasions where patients had been smoking on

the ward or in bedrooms. Staff had conducted bedroom searches and had investigated to try to stop patients bringing cigarettes onto the ward. At the time of the inspection this issue remained unresolved.

- Patients could use electronic cigarettes in their bedrooms and in small side rooms but not in the communal recreational areas. However, there was some inconsistency across the hospital as staff allowed patients on Bourn ward, the acute ward, to smoke tobacco cigarettes. On Ermine and Orwell wards, patients had acquired contraband tobacco cigarettes and staff were working to eliminate this but with limited success. This was in line with provider's policy at the time of inspection.

Safeguarding

- Staff received training in safeguarding children and adults. Compliance rates for both these courses were over 95%. The hospital had robust procedures in place to report safeguarding cases to the local authority and to the local NHS Trust who exercised oversight of safeguarding cases in the hospital on behalf of the local authority. Staff knew who the safeguarding lead was for the hospital and made referrals to the hospital's social work department. The safeguarding lead ensured they made appropriate referrals to the local authority. Staff could refer directly or contact the police, where this was necessary and appropriate.
- The provider had close working relationships with the trust and local authority and referred to the police where appropriate.
- Most staff knew how to identify abuse and worked to keep patients safe. However, on Icknield ward, two patients told us some staff prodded some patients' feet and legs with a key if they were reluctant to get up. Patients had not raised this with staff or managers, but some had started to sleep with trainers on or change their sleeping position to stop this from happening. We raised this with the provider during the inspection, who undertook an immediate investigation, interviewed staff and patients and acted on the findings. The provider took action against one staff member.
- The provider had procedures in place for children visiting the wards, and designated rooms for families visiting their relatives.

Staff access to essential information

- Staff used an electronic recording system to record the majority of patient notes. This included risk assessments, care plans, daily notes and incident forms. Staff completed seclusion paperwork on paper records and kept this on the wards. Staff referred to policies and procedures on the computer system's shared drive but would sometimes print these out to keep on the ward. This could mean that staff did not always refer to the most recent version.
- Staff told us that access to information was sometimes problematic as the system was slow and did not always work well. Inspectors also found this was the case, especially on the ward computers.
- All permanent staff members could access the electronic system with their own individual password. Some agency staff could only access the system using a guest account which did not recognise who was inputting information. However, the hospital confirmed that there was a tracking system in place to manage this.

Medicines management

- The service used systems and processes to prescribe, administer, record and store medicines. We looked at 34 prescription cards. On Ermine ward there was an error in the recording of a controlled drug where the record stated there were a number of tablets which staff had not stored in the controlled drugs cabinet. We raised this with the provider who investigated and accounted for this as a recording error. On Clopton ward, seven of the eight records we checked and on Icknield ward, 12 of the 13 records did not record a review for as-required medication in the previous 14 days. Some of the clinic rooms were not well organised.
- The provider did not always administer medication in line with best practice. We found four syringes, specifically used to administer liquid medicines, standing in pots of water with patients' initials written on kitchen paper beside each one.
- Staff recorded information about patients' allergies appropriately on prescription records. However, staff had not routinely transferred this information onto the electronic recording system. We raised this with the provider during the inspection, who addressed this promptly.

Inadequate

Forensic inpatient or secure wards

- The provider had a contract with a local pharmacy who attended the wards weekly to ensure medication was available when required and that all medication was accounted for. The pharmacist checked medication charts for errors, ensured that medication was ordered when required and undertook audits of the clinic rooms. Staff also conducted audits to ensure that staff adhered to protocols and that medication was stored correctly and in date. However, there were gaps in these audits on Orwell ward and audits had not addressed issues in relation to the clinic room environment, medication administration and as-required medication.
- Staff regularly reviewed the effects of medications on most patients' physical health at ward rounds and more frequently when required. However, one patient on Ermine ward did not receive appropriate physical health checks.

Track record on safety

- The provider reported that there had been 12 serious incidents in this service in the previous 12 months prior to inspection. These included a patient setting fire to a chair, injuries to staff and incidents of self-harm. The provider investigated these incidents appropriately.

Reporting incidents and learning from when things go wrong

- Staff were aware what incidents they needed to report and how to report them on the electronic reporting system. Managers reviewed incidents and ensured staff took appropriate action when needed.
- Senior managers reviewed all incidents at the morning meeting to determine any actions required and lessons learnt. Senior managers then fed back to ward managers, who shared feedback with ward staff at handover meetings and staff team meetings. Staff we spoke with told us they discussed learning in handovers, debriefs and supervision.
- The provider produced a monthly 'lessons learnt' bulletin which the provider circulated to all staff; this was discussed as part of the reflective practice sessions that staff attended every eight weeks.
- Staff received a debriefed after incidents.

Are forensic inpatient or secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff completed comprehensive mental health assessments for patients after admission and updated these regularly, usually six-monthly. We reviewed 22 patient records across four wards. Assessments detailed historical and current patient information.
- Staff completed physical health assessments for most patients and reviewed these regularly. All patients' records demonstrated that staff monitored patients' physical health issues regularly throughout their stay.
- Staff developed care plans for patients that were personalised, holistic and recovery oriented. Care plans reflected the needs identified in assessments and staff updated them regularly when required. Patients received copies of their care plans, but evidence of patient involvement was extremely limited.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. This included cognitive behavioural therapy, schema therapy and treatments linked to patients' offending history such as fire-starting and managing sexually problematic behaviour. Doctors prescribed medication and reviewed this regularly and monitored patients' physical health in line with national guidance. Staff delivered drug and psychological therapies in line with National Institute for Health and Care Excellence guidance.
- Staff from the employment and vocational opportunities service (EVOS) provided vocational sessions in a variety of topics, including music, photography, renovation, gardening and animal care. Patients also had access to some paid employment roles, for example, vehicle valet, cafe assistant, gardener and retail assistant.
- Patients had good access to physical healthcare. GPs, chiropodists, dentists and a physical health nurse visited the wards regularly and patients could see these by appointment. Staff referred patients for specialist

medical services when required. A number of the nursing staff received training to take blood and use the electrocardiograph machine, so they could access results quickly. We looked at 22 patient records. All indicated that staff had completed physical health assessments on, or shortly after, admission and were monitoring most patients' physical health appropriately. However, one patient did not receive a physical health assessment until over two weeks after admission and on patient on Ermine ward did not receive appropriate health checks.

- Staff encouraged the use of the gym and provided advice about obesity and healthy eating. Staff provided help with smoking cessation and encouraged and facilitated the use of e-cigarettes. Staff provided advice about substance misuse.
- Clinical staff and managers completed clinical audits, for example for medication, environment and ligature risks. Staff monitored patients' progress through ward rounds and other multidisciplinary meetings such as care programme approach.

Skilled staff to deliver care

- The provider had a robust multidisciplinary team consisting of seven responsible clinicians, three specialty doctors, occupational therapists, psychologists, social workers and nurses. The provider also accessed dieticians, chiropodists, dentists and GPs where necessary. All wards had access to specialists to meet the needs of patients.
- Registered nurses and multidisciplinary staff were experienced and qualified. New staff received a two-week induction which included mandatory training and shadowing staff before working on the wards. This was in line with care certificate standards.
- Managers supervised staff regularly. Staff we spoke with told us that they received monthly face to face supervision and could ask for support and advice when they needed it. Supervision compliance was 100% on Ermine ward and Orwell ward, 93% on Icknield ward and 90% on Clopton ward.
- The provider did not submit data to demonstrate how many staff completed an appraisal in 2019. The provider stated a 98% compliance rate across the whole hospital in April 2018. They reported that since moving to the new Priory Healthcare system, all staff should complete their appraisal in February and March each year. Most staff we spoke with said they had received an appraisal every year. However, one staff member we spoke with told us they had not had an appraisal for over three years.
- Staff had access to regular team meetings, including the TR6 training and reflective practice meetings where they discussed a range of general and ward related issues. Staff had access to specialist training when required.
- Managers dealt with poor performance through the supervision process. Between 31 January 2018 and 15 March 2019, seven staff members were suspended or under supervision. One of these was dismissed and one staff member remained suspended at the time of the inspection.

Multidisciplinary and interagency team work

- The provider had a robust multidisciplinary team. Staff held regular and effective multidisciplinary meetings. The provider held daily meetings, attended by doctors, nursing staff and members of the senior management team. Staff dealt with issues arising from the whole hospital, informed by ward managers and morning handovers for each ward. Staff held regular multidisciplinary ward rounds for patients. We attended one ward round meeting, involving a doctor, social worker, psychologist, ward manager and the patient. The discussion involved the patient; professionals listened to the patient's views and acknowledged them. There was evidence of close multidisciplinary working and efforts to keep the patient in regular contact with their family.
- Staff held handover meetings twice a day between shifts. We attended two handover meetings, on Ermine and Orwell wards. Staff discussed information about each patient individually, identified relevant actions for the oncoming shift and reviewed observation levels. Staff kept handover records in the nursing office for staff who were unable to attend.
- The service had effective relationships with external agencies, for example, GPs and other healthcare professionals, the local authority, local NHS Trusts, local commissioners and NHS England. However, staff and patients spoke about the time taken to make decisions by external organisations such as the Ministry of Justice.

Inadequate

Forensic inpatient or secure wards

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

- Ninety-two per cent of staff across the hospital had received training in the Mental Health Act. Staff had a good understanding of the act and the guiding principles.
- Staff had easy access to administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice. Staff knew who their mental health act administrator was and accessed them for support when needed.
- The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. This was accessible to staff on the shared drive on the electronic system.
- Patients had access to independent mental health advocacy. However, there had been a recent change of provider and not all leaflets on the wards showed the current provider.
- Staff requested a second opinion appointed doctor when doctors had assessed that patients lacked capacity and kept forms T2 and T3 with patients' prescription charts. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate issued by a second opinion appointed doctor and is a form completed to record that a patient is not capable of understanding the treatment prescribed or has not consented to treatment but that the treatment is necessary and can therefore be provided without the patient's consent.
- Staff explained to patients their rights under the Mental Health Act and recorded this. However, on Orwell ward, it was unclear that one patient had understood their rights when read to them. Staff did not repeat this until the next scheduled date.
- Staff ensured patients were able to take Section 17 leave and completed and stored the paperwork appropriately. Two patients' records did not contain information following their return from leave.
- The provider stored detention paperwork securely and staff had access to it when needed. The provider did regular audits to ensure they applied the Mental Health Act correctly.

Good practice in applying the Mental Capacity Act

- Ninety-two per cent of staff across the hospital received training in the Mental Capacity Act. Staff had a good understanding of the act and how it applied to their work.
- Ninety-three per cent of staff received training in Deprivation of Liberty Safeguards. There had been no Deprivation of Liberty Safeguards in the previous 12 months prior to inspection.
- The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it and where to get advice from within the provider regarding the Mental Capacity Act.
- Staff assumed patients had capacity to make decisions for themselves and assisted them to make decisions for themselves before assessing whether the patient lacked the mental capacity to do so.
- Staff assessed and recorded capacity to consent appropriately. This was on a decision-specific basis about significant decisions. There was evidence of this recorded on patients' care records.
- When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- The service had arrangements to monitor adherence to the Mental Capacity Act.

Are forensic inpatient or secure wards caring?

Inadequate

Kindness, privacy, dignity, respect, compassion and support

- Some staff were not caring. Seven patients said some staff did not interact with them positively, did not always listen to them, were rude, unfriendly or antagonised patients. Two patients said they did not trust staff, others said some staff were not interested or ignored them, and that one staff sometimes threatened them with seclusion if they did not behave differently. One patient we spoke with told us a member of staff had mocked them over a private issue. However, most staff were discreet, respectful and responsive to patients and provided advice and emotional support when they

needed it. We spoke with 18 patients individually and attended two community meetings and a group discussion on Icknield ward. Patients we spoke with told us most staff were caring, considerate, approachable and helped explain things to them. We observed staff interacting with patients in a kind, caring and supportive way.

- Staff on Icknield ward did not always display kindness, dignity, respect and compassion for patients. We were concerned that two patients we spoke with told us that some staff used keys on their feet and legs if they were reluctant to get up. We raised this with the provider who investigated and took immediate action.
- Staff helped patients understand and manage their care where possible. Staff directed patients to specialist services and enabled them to access those services.
- Most staff understood the individual needs of patients. Patients could attend religious services and access a chaplaincy service for a variety of faiths as required.
- Staff we spoke with said they could raise concerns about abusive and discriminatory practices towards patients without fear of the consequences. Staff maintained confidential information about patients appropriately.

Involvement in care

- Staff did not involve patients fully in formulating their care plans. We reviewed 22 patient records. In 18 of these, documentation did not reflect that patients had been involved in their care plans and risk assessments or that involvement was extremely limited. Six patients on Icknield ward said that staff wrote their care plans and they had not been involved in this process. However, most patients had access to their care plans and received copies of them. They were involved in ward rounds and care programme approach meetings and able to speak to their named nurse when needed. Patients were involved fully in the ward round meetings we observed. One patient on Ermine ward said they had not received a care plan and staff had not explained their treatment to them.
- Staff talked to patients about their care and treatment in ward rounds and other multidisciplinary meetings. Patients had good access to doctors, who discussed and reviewed patients' treatment and care regularly.
- Staff used the admission process to inform and orient patients to the ward and to the service. Staff gave patients an information booklet and showed patients around the ward on admission. The wards had a 'buddy system' where new patients on the ward were allocated peer support to help orient them on to the ward on admission.
- Patients were able to feedback about the service and make requests to managers. Each ward held regular community meetings and encouraged patients to chair these meetings. We attended two community meetings on Icknield and Orwell wards. On Ermine ward, both staff and a patient took notes at the meeting. However, meeting minutes rarely recorded feedback from the previous meeting, including responses to patient requests.
- Staff enabled patients to access advocacy. However, some information displayed on the wards was out of date and two patients we spoke with said they would not know how to access this service.
- Staff involved families and carers appropriately. We spoke to seven carers. Six carers we spoke with said staff informed them regularly about their relative's care and invited them to multidisciplinary meetings appropriately. The provider offered support to carers and offered opportunities to feed back about the service through regular carers meetings. Carers who had attended these said they found it positive. However, one carer we spoke with said they did not feel the concern they had raised had been listened to.

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

(for example, to feedback?)

Good

Access and discharge

- Between 1 June 2018 and 31 December 2018, the average bed occupancy was 97% on Clopton and Icknield wards, 94% on Orwell ward and 93% on Ermine ward. On Wimpole ward, which closed in December 2018, the average bed occupancy was 38%. The provider submitted data stating the average length of stay for current patients was highest on Icknield ward at 435 days and lowest on Ermine ward at 51 days.
- The ward accepted patients from out of area. Patients were discharged to suitable placements near home if possible. Icknield ward was due to close in June 2019

and the provider worked effectively with commissioners to support patients to other placements closer to home. The provider had also undertaken work to prepare Icknield patients for the ward closure. However, there was little active discharge planning, with the involvement of patients, reflected in individual patient records, including for patients on Icknield ward.

- Patients did not access home leave frequently as the hospital was a medium and low secure service. However, beds were always available when patients returned from leave.
- Staff moved and discharged patients at appropriate times of day and did not move patients between wards unless this was justified on clinical grounds. Doctors were always on site to oversee this process and meet patient need.
- In the last 12 months prior to inspection the provider reported that there had been one delayed discharge from Orwell ward.
- Staff supported patients to access acute hospitals for treatment when necessary.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. However, none of the patient bedrooms on any wards were en-suite so all patients had to share bathrooms and shower facilities.
- Patients were able to personalise their bedrooms. We saw examples where patients had pictures and personal belongings displayed in their rooms.
- Patients could store possessions on the wards. The provider used rooms as store cupboards which patients did not have access to. Patients could not easily store possessions securely in their room. Two patients we spoke with told us some of their possessions had gone missing.
- There was a range of rooms on the ward which patients could access. These included some small, quiet rooms, where patients undertook therapy or activities, and larger communal areas for games or for watching television. There were rooms for meeting visitors just off the ward. Patients could make telephone calls in one of the telephone booths or by using their mobile phones.
- Patients had access to outside space. Each ward had small areas which patients accessed. Some patients had access to escorted and unescorted leave in the hospital grounds and in the local community. This was individually risk assessed.
- Five of the 11 patients who commented on the food, said that it was of poor quality and that there was a lack of variety. Six patients we spoke with said the food was of good or acceptable quality.
- Patients were able to make drinks and had access to snacks.

Patients' engagement with the wider community

- Staff ensured patients had access to work opportunities within the hospital. There were a number of paid jobs which staff encouraged patients to apply for.
- Staff supported patients to maintain contact with their families where appropriate. Staff escorted patients on community leave to access local community facilities after they had risk assessed and authorised this.

Meeting the needs of all people who use the service

- Staff produced accessible versions of care plans for patients who found this helpful.
- The service could not meet the needs of patients with significant mobility issues. Ermine, Icknield and Orwell wards were on two levels, with bedrooms located upstairs. Clopton ward was on one level but access at weekends was through the reception for the other three wards. This meant that staff and patients had to go upstairs and then down again to exit and enter the ward. The service had no lifts. Managers said they took this into account when accepting referrals.
- Staff displayed information on notice boards about treatments, rights, advocacy and how to complain.
- Staff used interpreters when needed to communicate with patients who first language was not English. Staff said they would approach the social work team or their managers if they needed access to leaflets in other languages.
- Staff produced food to meet the dietary requirements of religious and ethnic groups. Staff ensured patient had spiritual support when they needed it. The Anglican chaplain delivered a service at the hospital once a week and a local Imam visited the hospital monthly to speak and pray with Muslim patients.

Inadequate

Forensic inpatient or secure wards

Listening to and learning from concerns and complaints

- In the previous 12 months prior to inspection there were 30 complaints. Eight complaints were upheld, six were partially upheld, 15 were not upheld and one was withdrawn. None of the complaints were referred to the ombudsman. Twelve complaints were raised in relation to Clopton ward, 10 for Wimpole ward and five for Orwell ward. There were no clear themes to these complaints. However, three complaints relating to staff attitudes towards patients, were upheld in this period. These included a member of staff making a racial comment about skin colour and a staff member entering a patient's room without knocking.
- The provider had systems for the recording and management of complaints. When staff received a complaint, managers wrote to the complainant to acknowledge receipt and explained the process. We reviewed 10 complaints; staff responded to all within the required timescales.
- Most patients knew how to complain, and some had made complaints. One patient we spoke with said he did not know how to make a complaint; another patient we spoke with said they had not received a response to a complaint that they had made. One carer we spoke with said they felt the service had not investigated their complaint fairly.
- The hospital employed a patient experience and improvement co-ordinator who supported the complaints process.
- Staff we spoke with said they would raise concerns about patient treatment without fear of any negative consequences. However, seven of the complaints raised were in relation to staff treating patients in a rude or discriminatory way. Three were upheld or partially upheld and four were not upheld.
- Staff knew how to handle complaints appropriately and acted on the findings of investigations.
- Patients raised concerns about issues on the ward individually and through community meetings. Responses to patient concerns were not always well documented.

Are forensic inpatient or secure wards well-led?

Inadequate

Leadership

- Leaders demonstrated that they understood their services and patients. Leaders knew the challenges they faced, particularly in relation to the ward environment.
- Leaders were visible in the service. On all four wards, they were available to and approached by staff and patients.
- Leadership development opportunities were available, including opportunities for staff below team manager level. The provider had developed a preceptorship programme for prospective nurses and was introducing trainee nursing associate posts.

Vision and strategy

- The Priory Group state that their purpose and key behaviours are putting people first, being supportive, acting with integrity, striving for excellence and being positive. They also highlight the seven Cs of care, compassion, competence, communication, courage, commitment and consistency. The senior leadership team had formally communicated this to frontline staff and had developed a vision and commitment to provide high quality care to patients.
- Staff had opportunities, through team building activities, team meetings and 'your say forum' to participate in discussions about the service.

Culture

- The provider had not ensured that all staff did not use punitive approaches or terminology with patients since raised at the last inspection. We found evidence of some institutional practices, such as rising and bedtimes and periods when patients were confined to downstairs or upstairs areas. Patients on Icknield ward said that some staff often spoke to each other in their own language. Two patients said staff could be rude or unkind. Four patients said that staff spent too much time in the office and not enough time on the ward. Another patient we spoke with told us a member of staff had mocked them over a private issue. The provider also upheld three

complaints about staff behaviour towards patients. These included a member of staff making a racial comment about skin colour and a staff member entering a patient's room without knocking.

- Two patients on Icknield ward told us that some staff used keys on their feet and legs if they were reluctant to get up. We were concerned at the time of this inspection that these attitudes may have been embedded. We raised this with the provider during the inspection and they took immediate action. The provider investigated and took action against one staff member.
- Most staff we spoke with said they felt positive about working in their teams and managers supported them well.
- Most staff we spoke with said they were able and confident to raise concerns without fear of retribution. Staff knew the whistle-blowing policy and knew how to use it. There were posters on the wards to inform staff.
- Managers dealt with poor performance through the supervision process. Staff teams supported each other well and morale across the service was good. Staff sickness rates across the hospital were low at 2%.
- The provider employed an equality and diversity lead to support staff and take the lead on the equality and diversity strategy.
- Staff accessed support for their own physical and emotional health needs through an occupational health service. The provider employed a staff welfare officer and welfare checks for staff was an agenda item at the morning management meetings.
- Supervisors discussed professional and career development with staff within appraisals and supervision, for example, in relation to nurse training.

Governance

- The provider had not fully addressed all areas of concern from the previous inspection. Managers made the ligature risk audit available to staff, but this was difficult to locate on Ermine ward and the electronic version was not the most recent on Ermine and Orwell wards. The provider had not resolved the ligature risks on seclusion room door hinges. There were still issues in relation to medication and the clinic rooms. Contraband items such as cigarettes were still entering the ward. The provider had not ensured that seclusion practices were in line with the Mental Health Act Code of Practice. Access to information continued to be problematic, meaning access to care plans and risk assessments, particularly for bank and agency staff was not assured. There were also issues with the quality of community team meeting minutes on Ermine ward.
- Managers had not ensured that there were effective processes to inform them of poor practices in different parts of the service and could not therefore take immediate steps to address them.
- Managers had not ensured that there was an effective process in place to ensure that clinic rooms were properly equipped and organised. Staff participated in clinical audits such as medication, ligature risk and blind spot audits and took some actions to address issues raised. Pharmacists also participated in audits in relation to clinic rooms. However, we found numerous issues in relation to medication and the cleanliness and maintenance of the environment and where staff had not rectified poor practices.
- Managers had not ensured that staff kept clear maintenance logs and enabled staff to keep track of faults that had been reported.
- Ward managers worked to a clear framework to ensure they shared information about complaints and incidents with the team. Managers held monthly lessons-learned meetings where they reviewed incidents. This included incidents from the whole hospital site and other hospitals across the organisation.
- Staff acted on concerns from incidents, safeguarding referrals and complaints raised by patients and carers. Managers tried to find solutions to difficulties where possible.
- Staff understood the arrangements and protocols in place to work with other teams. For example, for reporting safeguarding referrals to the hospital social work team and working with NHS England and patients' commissioners.

Management of risk, issues and performance

- The provider had not ensured that there was sufficient staffing to address the challenges caused by the layout of the Ermine, Icknield and Orwell wards. This led to staff imposing rules on patients to compensate for the difficulties in staffing both floors of these wards and led to additional risks for staff and patients. We raised this with the provider during the inspection and they removed the restrictions to upstairs and downstairs

areas. However, staff on Icknield ward told us this had not led to an increase in staffing numbers and made it more difficult to ensure some patients could access their section 17 leave.
- The provider had taken measures to reduce the amount of restrictive interventions across the service. However, we found that there were restrictive practices on three of the four wards in relation to confining patients to certain areas of the ward.
- Ward managers were aware of the local risk register and said they could contribute to this. This was accessible on the shared drive on the electronic system.
- The hospital had plans for emergencies. For example, serious outbreak of infection or pandemic, and severe weather conditions.

Information management

- Managers accessed a dashboard to assess the performance of the team. This included information on supervision and appraisals and compliance with mandatory training. Managers used this effectively to ensure staff were up to date with training and supervision. Systems used to collect information did not place a burden on frontline staff.
- Staff made notifications to statutory bodies such as safeguarding, Care Quality Commission. NHS England and commissioners.
- The provider's electronic systems were slow, and staff sometimes experienced difficulties in accessing information quickly. Inspectors experienced this issue during the inspection. However, the provider stored information securely and confidentially and this was available to staff when needed.
- The ward had effective systems in place for staff to report to external bodies. We saw evidence of this where staff had reported safeguarding concerns.

Engagement

- Staff had access to information about services. There were regular team meetings, bulletins, e-mails and newsletters giving updates when necessary. There were posters for patients in relation to services within the hospital, including treatments, advocacy, rights, activities and employment opportunities. However, information was not always easily accessible or up to date. For example, there were notices on Ermine ward about the printed ligature risk assessment, but this was difficult to locate and when located was not the most recent version. Ermine and Orwell wards did not make clear where emergency equipment was located and there were out-of-date posters for independent mental health advocacy services.
- Patients and carers had opportunities to feedback about services. Patients raised concerns with managers through community meetings and monthly service user council meetings, attended by representatives from each ward and by senior managers. Carers fed back though quarterly meetings, an annual open day and regular care programme approach meetings.
- Managers and staff responded to concerns raised with them. Service users' council meetings documented issues raised and tracked the response. However, community meeting minutes did not consistently record the responses to issues raised by patients at the previous meeting.
- Senior managers and ward managers engaged with stakeholders such as NHS England and patients' commissioners.

Learning, continuous improvement and innovation

- Staff had participated in a schizophrenia audit in the last 12 months prior to inspection.
- The hospital participated in the Quality Network for Forensic Mental Health in March 2018. The service met 83% of the quality standards. The hospital was currently involved in annual peer review at the time of our inspection.

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Requires improvement

Safe and clean environment

- There were numerous blind spots and points that could be used to self-ligature throughout the wards. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. All wards had up to date ligature risk assessments which included each ligature point and actions taken to reduce the risk. The risk assessments were long documents and for staff unfamiliar with the ward it was difficult to see an overview of where high-risk areas were.
- Staff used their knowledge of patients, individual risk assessments and observations to mitigate risks, including ligature risks. The provider had installed convex mirrors on the wards to enhance patient safety and aid observation of blind spots.
- Staff did regular risk assessments of the care environment. On each shift, a member of staff was nominated as the security officer for that shift and was responsible for checking the ward environment. This included walk-rounds of the ward environment and perimeter and checks of equipment such as cutlery, radios and alarms, ligature cutters and fire equipment.
- Staff carried personal alarms at all times to call for assistance if required. Patients had nurse call alarms in their bedrooms on Nightingale and Fairview wards; on Wortham ward, the Bungalows and Swift House, personal safety alarms were available to patients as appropriate.
- The wards were single gender and so complied with guidance on eliminating mixed-sex accommodation.
- There were no seclusion rooms on any of the rehabilitation wards. On the rare occasions where a patient required seclusion, staff managed this by moving the patient to a different ward with a seclusion room. One member of staff told us this could take some time to arrange and could impact on staff managing such incidents as it caused more prolonged stress for staff and patients.
- Ward areas were mostly clean, however the environment on all rehabilitation wards was tired, and many areas needed redecoration and repair. During the inspection, we observed broken flooring and peeling wallpaper in Bungalow 67. On Fairview we observed chipped paintwork, areas of broken plaster on the walls and scratches on the perspex windows and on the windowsills.
- Kitchen areas were clean and tidy. We found out of date milk in the fridge in Swift and some out of date eggs in the kitchen in Nightingale. We raised this with the ward manager during the inspection.
- During the inspection we observed bagged clinical waste stored untidily. For example, there was bagged clinical waste stored in the office on Swift. Staff acknowledged that there was an opportunity to improve practice in this area and conducted a waste audit during the inspection. Following the audit, staff produced an immediate action plan in conjunction with the external provider of waste disposal.

Long stay or rehabilitation mental health wards for working age adults

Good

- Staff adhered to infection control principles, including handwashing. At the time of the inspection, 90% of staff had completed mandatory training in infection control.
- The clinic rooms on Nightingale and Wortham were visibly clean, tidy and fully equipped to enable staff to prepare medications and undertake physical health monitoring effectively and safely. The clinic room on Wortham ward was small and cramped, however there was adequate space to dispense medications. Emergency grab bags containing resuscitation equipment had the appropriate content and had all the correct checks recorded for the three months prior to inspection.

Safe staffing

- Managers had calculated the number and grade of nurses and healthcare assistants required based on patient need. Rotas we checked showed that the number of staff on shift matched the estimated number required.
- The ward manager could adjust staffing levels daily to take account of case mix and levels of acuity on the ward.
- During the inspection, we observed that the hospital workforce co-ordinator and ward managers discussed staffing during a daily workforce meeting to ensure they covered any gaps in rotas and there was an appropriate skill mix across the wards.
- Managers for all wards told us that, where possible, they offered overtime to existing staff to cover sickness and leave absences. If this was not possible, managers used bank or agency staff to cover absences. The Bungalows reported the highest use of agency staff with 231 shifts covered by agency staff between January and December 2018. Nightingale ward reported 87 shifts, Wortham ward reported 62 shifts and Fairview ward reported 140 shifts covered by agency staff.
- Managers told us they tried to use block booking for agency staff, so they would have staff that were familiar with the ward and patient group. However, six patients we spoke with told us that their regular permanent and bank staff were often moved to cover gaps in staffing on other wards and this had an impact on their ability to build relationships with staff due to subsequent high use of agency staff. One patient told us that it could be difficult to approach a 'stranger' when there were frequent changes of agency staff.
- Staff we spoke with told us that five new members of staff had just been recruited to work 9am – 5pm every day across the rehabilitation wards, including at weekends. Managers told us this felt positive for patient care and staff morale as they would have more cover on the wards and an extra person to attend to patients and accompany them to activities and when they had leave off site.
- The wards all had a consultant in post, sometimes shared with other wards and staff reported that patients had good medical cover. Consultants delivered an out of hours service on a rota and were based on the hospital site so that they could attend quickly at night.
- Staff had received and were up to date with appropriate mandatory training.
- Overall, over 75% of staff in this service had undertaken all the various elements of training that the provider had set as mandatory. All mandatory courses had a compliance rate of over 90% across the hospital, except for basic life support, which had a compliance rate of 75%.

Assessing and managing risk to patients and staff

- The provider used the Historical Clinical Risk Management tool (HCR20) for patients with an assessed risk of violence, and the Short-Term Assessment of Risk and Treatability for patients without an assessed risk of violence. Staff completed a more detailed HCR20 risk assessment for patients who had historical or current incidents of being a risk to others. Staff updated this every six months and/or after incidents.
- Staff involved patients in discussing their current risks during monthly ward rounds and documented this in individual care records. The clinician made the final decision, but if a patient disagreed with the clinician about their current level of risk, this was explained, and the patient's views documented clearly.
- We looked at 24 care and treatment records and found three patient records that did not contain a detailed risk assessment or a HCR20 assessment, despite care notes showing that they had a history of violence, aggression or sexual offending towards others. For two of these patients, there was a clinical justification as to why the completion of a HCR20 was not appropriate.
- We were concerned that one patient with a history of sexual risks, who had also been subject to allegations of sexual assault, did not have appropriate risk assessments completed with no recorded justification

for this decision. We were also concerned that this patient had present risks following a documented conversation with a member of staff. Staff had not taken any action following this conversation and we could not see a robust risk assessment in place, including a review of the risks associated with unescorted leave. We raised this at the time of inspection and staff reviewed and updated the patient's risk assessment.

- Patient allergies, including those that were potentially life-threatening, were not recorded on individual care records. Patient prescription charts contained details of allergies to medicines, but staff had not transferred this information to care records and did not include full details of food allergies. We brought this to the attention of the medical director during the inspection and this was rectified for all patient records by the end of the inspection period.
- None of the wards had any blanket restrictions in place and staff were committed to least restrictive practice. Patient care records demonstrated positive risk taking and individual risk assessments. A doctor told us that positive risk taking was particularly well managed on Nightingale ward.
- Informal patients could leave at will and knew that. Staff carried out a five-point risk assessment for patients going out on section 17 leave.
- Staff used restraint only after de-escalation had failed. The provider had introduced updated prevention and management of violence and aggression training and staff were no longer taught prone or supine restraint techniques. For management of longer-term restraints, and the administration of rapid tranquilisation, holds were undertaken in safety pods which had eliminated the use of prone restraint and restraint on staircases.
- At the time of the inspection, over 90% of staff were up to date with training in managing violence and aggression.
- In the period January 2018 to December 2018, there were 6 episodes of seclusion. These were highest in Nightingale. There were 20 episodes of restraint, of which none were prone restraint.
- Due to the low number of seclusions, the rehabilitation wards did not have a seclusion room and patients who needed seclusion were moved to an acute or forensic ward to facilitate this.

Safeguarding

- The hospital provided figures which showed that 97% of staff were trained in safeguarding vulnerable adults and 96% were trained in safeguarding children. Staff knew how to make a safeguarding alert and did that when appropriate. Staff knew who the safeguarding lead was for the hospital.
- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.
- The provider had procedures in place for children visiting the wards, and designated rooms for families visiting their relatives.

Staff access to essential information

- All staff had access to the electronic patient information system. Staff we spoke with felt they could find the information they needed on the system, however it could be very slow and freeze occasionally. One member of staff we spoke with told us that the system was not fit for purpose. One ward manager told us that the slowness of the system caused delays in signing patients in and out from leave. During the inspection, we observed difficulties with logging onto the system and slow running when navigating between screens.

Medicines management

- We reviewed 21 prescription charts and found there was effective medicine management. Prescription charts had a photo of the patient to aid with identification for staff not familiar with the patient, and a mental capacity assessment form. Staff stored medicines in accordance with the manufacturers' guidelines.
- Staff ensured that medicines including controlled drugs, emergency medicines and medical gases, were stored securely. Staff checked equipment and calibration records daily. Staff monitored the temperatures of medicine storage fridges. Staff disposed of medicines appropriately.
- As part of their rehabilitation, staff supported some patients to manage their own medication. Staff carried

Long stay or rehabilitation mental health wards for working age adults

Good

out checks to ensure that patients understood their medication and were taking it correctly. Patients we spoke with appreciated the opportunity this gave them to manage their own healthcare.
- Staff checked equipment and calibration records daily. However, staff told us that some ward equipment, such as thermometers, were recording incorrect results and physical health staff carried their own equipment because of this.
- The provider had contracted an independent pharmacy who audited medicines management including reconciliation and error reporting.

Track record on safety

- Between January 2018 and December 2018, there were five serious incidents reported on the rehabilitation wards. There were two incidents of self-harm, one incident of harm to others and one incident where a patient was reported missing to the police after they did not return from leave.

Reporting incidents and learning from when things go wrong

- Staff reported incidents on an electronic system. All staff members had access to this system and received full training on how to complete this on induction to the hospital. All staff we spoke with knew what incidents to report and how to report them.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.
- Senior managers reviewed all incidents at the morning meeting to determine any actions required and lessons learnt from incidents. Senior managers then fed back to ward managers, who shared feedback with ward staff at handover meetings and staff team meetings.
- The provider produced a monthly 'lessons-learned' bulletin which managers circulated to all staff. Staff discussed these in reflective practice sessions that staff attended every eight weeks.
- Staff received a debrief and support after a serious incident.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Patients had comprehensive care plans that were holistic, and patient focused. We reviewed 24 care and treatment records. Care plans included four domains, including 'keeping safe' and 'keeping connected'. In addition, some patients had special arrangements care plans, for example for medical conditions or the use of mobile phones. Some patients displaying challenging behaviour had positive behaviour support plans.
- Patients we spoke with told us staff had offered them copies of their care plans and they had the opportunity to discuss their care and treatment at monthly ward rounds.
- Care records showed that staff completed physical health examinations on admission and monitored patients' physical health throughout their treatment. However, we could not see evidence that all patients on high dosage anti-psychotic medication had received a six-monthly ECG in accordance with National Institute for Health and Care Excellence guidelines.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group, as recommended by, and delivered in line with, guidance from the National Institute for Health and Care Excellence. These included medication, psychological therapies and activities, training and work opportunities intended to help patients acquire living skills.
- Patients had good access to psychology support, including weekly groups and individual sessions.
- Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. The provider employed three physical health nurses who conducted physical health checks and liaised with the GP who visited on a weekly basis. We saw evidence of access to dental, optician and chiropody services in patient care records.

Long stay or rehabilitation mental health wards for working age adults

Good

- The provider had a physical health strategy in place which focused on key areas of action including smoking cessation, obesity, the reduction of substance misuse and dental and oral health. Patients we spoke with told us staff encouraged them to use the gym and make healthy eating choices. We observed fresh fruit available on all the rehabilitation wards during the inspection.

Skilled staff to deliver care

- The provider employed a full range of specialists required to meet the needs of patients including, doctors and nurses, occupational therapists, psychology staff, therapy care assistants, social workers, dieticians, health care workers and catering and administrative staff.
- Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group.
- Managers provided new staff with appropriate induction. Patients were involved in new staff induction by giving talks to new staff to enable them to consider the patients' perspective.
- Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance.
- The provider policy was for staff to receive individual supervision every four weeks and group reflective practice sessions every eight weeks. The provider reported that between January and December 2018, 100% of staff on Nightingale and 94% of staff on Wortham were up to date with clinical supervision. The Bungalows had a lower reported rate at 71%, but managers had a plan in place to address this.
- The percentage of staff that had an appraisal during 2018 was 98%.
- Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge.
- Managers dealt with poor staff performance promptly and effectively.

Multidisciplinary and interagency team work

- Staff worked as part of a multidisciplinary team, which included doctors, nurses, support workers, social worker, psychologists and members of the Educational, Vocational and Occupational service. Staff told us there was effective multidisciplinary working with good, supportive relationships between nursing and therapy staff.
- There were monthly multidisciplinary team meetings held for each patient to discuss attendance at activities and therapies, incidents, risks, goals and progression towards discharge. The patient, or a representative, were invited to attend these meetings and encouraged to share their views and experiences, including consideration of their current levels of risk. We observed four meetings and saw staff treating patients with respect and consideration, with the patient at the heart of the discussion.
- Staff across the wards reported working well together, providing staffing cover for each other when needed and joint assessments of patients to determine which ward would best suit their needs.
- We observed an effective morning handover meeting where staff shared information about patients including present mood and incidents that had occurred the previous day and overnight, as well as forthcoming events such as a patient celebrating their birthday that day.
- Staff described effective working relationships with the local authority and commissioners. Staff sent monthly reports to all commissioners, through care managers, detailing patients' progress and commissioners attended individual patients' Care Programme Approach Meetings (CPAs) every six months.

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

- At the time of the inspection, 95% of staff had had training in the Mental Health Act. Staff received training in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Patients had easy access to information about independent mental health advocacy. We observed posters displayed in all wards and patients we spoke with knew they could request to see an advocate if they needed to.
- Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done

Long stay or rehabilitation mental health wards for working age adults

Good

it. However, we found one patient record where a patient had not understood their rights on admission and staff had not repeated these or undertaken a formal capacity assessment.
- Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted.
- Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.
- The wards displayed notices to tell informal patients that they could leave the ward freely.
- The provider completed the healthcare division Mental Health Act (MHA) Audit in August 2018 for five patients per ward, who were detained under the Mental Health Act.

Good practice in applying the Mental Capacity Act

- The provider supplied figures to show that 93% of staff had training in the Mental Capacity Act.
- The rehabilitation wards did not have any Deprivation of Liberty and Safeguards applications over the past year.
- Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.
- For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent to treatment appropriately. They did this on a decision-specific basis with regard to significant decisions.

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

Good

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. We observed staff discussing patients in management and review meetings with care and respect.
- Staff supported patients to understand and manage their care, treatment or condition. Patients told us staff supported them appropriately to manage their own medication and self-cater.
- Patients we spoke with said staff treated them well and behaved appropriately towards them. They told us they felt safe and could trust staff with their feelings. One patient told us that it was more difficult to feel comfortable with agency staff as they changed frequently.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.
- Staff maintained the confidentiality of information about patients.

Involvement in care

- The wards had a 'buddy system' where new patients on the ward were allocated peer support to help orient them on to the ward on admission.
- Staff involved patients in care planning and risk assessment. We observed a structured ward round process which fully involved the patient, with a comprehensive range of topics relating to patients' care discussed.
- Staff involved patients when appropriate in decisions about the service – for example, in the recruitment of staff. Patients were involved in giving talks to new staff during their induction period.
- Staff enabled patients to give feedback on the service they received. Staff held Community meetings on the wards.
- The provider had a service user council made up of representatives from each ward who then attended a monthly meeting with the multidisciplinary team and a member of the senior management team. We spoke to the patient representative from Wortham ward who said that issues raised on behalf of the patient group were listened to and the provider took action where possible.
- Staff informed and involved families and carers appropriately and provided them with support when needed.

Long stay or rehabilitation mental health wards for working age adults

Good

- Staff enabled families and carers to give feedback on the service they received. The provider hosted a quarterly carers forum and an annual open day for carers. Following consultation with the carers' forum, staff and carers co-produced a training pack for staff.
- We spoke to four carers. All the carers we spoke with felt that staff were caring, however one carer told us that the personal hygiene of their family member had deteriorated since being at the hospital and staff did not encourage them to maintain this. Two carers felt that staff did not provide enough activities for their family members and did not motivate them to engage in activities off the ward.

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

Good

Access and discharge

- The provider reported the average bed occupancy was 83% for the Bungalow wards and 75% for Fairview ward. For Swift and Nightingale average bed occupancy was 75% and 76% respectively.
- The provider reported that that the average length of stay on Bungalow 67 was 679 days. Across the other rehabilitation wards the average length of stay was 232 days.
- Discharge planning commenced at the point of admission on to rehabilitation wards and the focus of care was recovery and leaving hospital.
- The provider reported one delayed discharge over the past year.
- The ward accepted patients from out of area. Patients were discharged to suitable placements near home if possible.
- Staff were able to move patients to a secure, acute or psychiatric intensive care unit ward if their health deteriorated, and we saw an instance of where this had happened on Fairview ward.
- The provider had a rehabilitation pathway and staff moved patients within the hospital to a less secure setting as their rehabilitation progressed and risks reduced. However, there were sometimes delays to moves due to Ministry of Justice restrictions regarding patients who had been in the criminal justice system. Staff reassured patients when this happened, discussed with them the reasons for the decision and ensured they had access to legal advice and advocacy where appropriate.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms available at the hospital, including clinic rooms, the educational, and vocational skill centre, which included a patient-run café, gymnasium and rooms suitable for therapy sessions. The hospital was set in spacious, pleasant grounds, so patients were able to access outside areas and take part in gardening and horticultural activities. One patient on Wortham ward took responsibility for maintaining the garden area outside the ward.
- Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. However, none of the patient bedrooms on any wards were en-suite; all patients had to share bathrooms and shower facilities.
- Patients could personalise bedrooms and we saw evidence of this throughout the inspection. Most patients had personal possessions in their rooms and they were individual to each person's wants and needs.
- There were quiet areas on the ward and a room where patients could meet visitors.
- The food was of a good quality. Patients we spoke with told us they liked the food and they could make themselves hot and cold drinks and snacks outside of mealtimes when they wanted to. We observed bowls of fresh fruit available for patients on all the wards.
- Some patients self-catered, as part of their rehabilitation, and were responsible for preparing and cooking their own meals and keeping kitchen areas clean. Staff supported all patients who self-catered to gain a food hygiene certificate before they cooked for themselves. Patients on Wortham ward had drawn up a rota to keep the kitchen clean and staff supported them with this.
- The dining room on Wortham ward only had nine chairs despite there being 16 patients on the ward. Staff told us that this did not cause any problems as patients ate at

Long stay or rehabilitation mental health wards for working age adults

Good

different times and some self-catered and ate in the upstairs kitchen. However, there was a plan to re-configure the dining room to allow more seating in that area.
- Patients were able to access community services and regularly attended escorted trips out into the community. Staff supported patients who were able to take unescorted leave to ensure they had the appropriate risk assessment before leaving the hospital site.
- The provider had an education and vocational skills centre where patients could learn skills such as do-it-yourself, animal care and horticulture, as well as participate in art and music sessions. There was also a café on site, available to all staff, patients and visitors, which sold hot and cold drinks, sandwiches and cakes. The café employed patients and supported them with food hygiene and customer service training. Other patients worked in the café or on the wards in voluntary roles.

Meeting the needs of all people who use the service

- The bungalow wards had disabled access for patients using a wheelchair; however, the other wards had bedrooms on the first floor and so were not accessible for patients with reduced mobility. There were no lifts installed in any of the wards.
- Staff displayed information leaflets on all wards; these included information on local services, advocacy services and hospital activities. Wortham ward had a 'you said, we did' board and good news and recognition boards.
- Patients could access spiritual support in the community using escorted or unescorted leave. The Anglican chaplain delivered a service at the hospital once a week and a local imam visited the hospital monthly to speak and pray with Muslim patients.

Listening to and learning from concerns and complaints

- Patients knew how to complain and raise concerns. Nightingale ward received two formal complaints in the previous year. The Bungalows received four complaints over the previous year. Two complaints were fully upheld, two were partially upheld and two were not upheld with none being referred to the ombudsman.
- The hospital employed a patient experience and improvement co-ordinator who supported the complaints process. Each rehabilitation ward had their own complaints log and those complaints that could not be addressed at ward level were referred to the complaints officer for investigation. A register of patient compliments and complaints is kept locally and discussed within the provider's monthly clinical governance meeting.
- When patients complained or raised concerns, they received feedback. The hospital investigated complaints and responded to complaints within the appropriate timeframe and apologised when required in line with the duty of candour.
- Staff protected patients who raised concerns or complaints from discrimination and harassment.

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

Good

Leadership

- Managers had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.
- Managers were visible in the service and approachable for patients and staff. All the staff we talked with spoke well of their managers and that they felt well supported. Staff felt that managers understood the challenges that they faced.

Vision and strategy

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff spoken with felt able to raise concerns without fear of retribution and were aware of the whistleblowing process.

Culture

- The provider did not report any bullying or harassment cases over the previous year on rehabilitation wards.
- Staff knew how to use the whistle-blowing process and staff told us that they felt confident to challenge colleagues if they observed poor practice.

Long stay or rehabilitation mental health wards for working age adults

Good

- Since the last inspection, the provider had appointed an equality and diversity lead to offer support to staff and take the lead on the equality and diversity strategy.
- Staff told us that they worked well as a team and helped each other. Staff felt valued and motivated to provide the best possible care for their patients.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. The provider employed a staff welfare officer and welfare checks for staff was an agenda item at the morning management meetings.
- We spoke with healthcare support workers who were training to be qualified nurses and saw that there were opportunities for development.
- The provider recognised staff success within the service – for example, through staff awards. One member of staff explained he had recently received an award and felt it was a recognition of his hard work.

Governance

- The provider had an electronic dashboard that enabled ward managers to see an overview of staff training, appraisal and supervision for their ward staff. Managers told us that this system worked well.
- There was a clear framework of items to discuss at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.
- The hospital conformed to the organisational clinical governance policy in which monthly quality walkarounds of the site were completed by senior staff members who have a standard audit template which is completed and then taken to site clinical governance for review.
- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.
- Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

Management of risk, issues and performance

- Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required.

Information management

- Staff told us that the electronic patient information system could be slow and freeze up which caused frustrations when they were trying to get tasks done quickly, including signing patients in and out of leave.
- Information governance systems included confidentiality of patient records.
- Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.
- The executive team sent a weekly bulletin to staff to update them with latest news.
- Staff made notifications to external bodies, including the Care Quality Commission, as needed.

Engagement

- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.
- Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Learning, continuous improvement and innovation

- Staff used quality improvement methods and knew how to apply them.
- Staff participated in national audits relevant to the service and learned from them.
- Wards participated in accreditation schemes relevant to the service and learned from them.

Outstanding practice and areas for improvement

Outstanding practice

- The rehabilitation and forensic wards had a 'buddy system' where new patients on the ward were allocated peer support to help orient them on to the ward on admission.
- Staff provided employment opportunities for patients, such as retail, working in the café, gardening and animal care.

Areas for improvement

Action the provider MUST take to improve

- The provider must rectify all the requirements raised by the previous inspection.
- The provider must ensure that equipment, staff alarms, search randomiser and emergency equipment, is properly stored, maintained and easily available.
- The provider must ensure all staff consistently follow policy about testing and resetting alarms on the wards.
- The provider must ensure that all ward areas, seclusion rooms and clinic rooms are clean and properly maintained.
- The provider must ensure best practice in relation to the safe storage, audit and administration of medication, in line with guidance.
- The provider must ensure patient information about allergies is documented on individual care records.
- The provider must ensure there are rigorous processes in place to prevent contraband items from entering the ward environments.
- The provider must ensure staff seclude patients and record seclusion in line with the provider's policy and the Mental Health Act Code of Practice.
- The provider must have robust plans to manage patients displaying challenging behaviour in upstairs bedroom areas.
- The provider must ensure staffing levels are sufficient to ensure that patients have access to the whole ward.
- The provider must ensure patients are safe and protected from improper treatment.
- The provider must ensure all patients on high dosage antipsychotic medication receive a regular electrocardiograph in line with national guidance.
- The provider must ensure staff respect patients' privacy and dignity and staff do not use restrictive practices to manage the ward environments.
- The provider must ensure staff complete robust risk assessments for all patients in a timely manner, and ensure identified patient risks are effectively managed, regularly reviewed and updated following incidents, including section 17 leave conditions.
- The provider must ensure staff consistently involve patients in care plans and risk assessments on all wards.
- The provider must ensure it has processes in place to identify and address poor quality care, such as using keys to encourage patients to get dressed.
- The provider must ensure an effective system is in place to record, action and monitor that all maintenance issues are highlighted and resolved in a timely manner.

Action the provider SHOULD take to improve

- The provider should consider the layout of all wards in relation to the number of levels on each ward and the provision of en-suite bathroom and shower facilities. Patients had to share bathroom and shower facilities.
- The provider should ensure consistent physical health checks on Ermine ward.
- The provider should review the system for recording community meetings to enable adequate monitoring of actions raised at previous meetings.
- The provider should ensure a consistent approach to patients' discharge planning in patient care plans and records.
- The provider should ensure sufficient staffing to ensure patients' therapeutic activities are facilitated as planned.
- The provider should ensure all staff follow policies for the disposal of clinical and general waste.

Outstanding practice and areas for improvement

- The provider should ensure that all agency staff can access their electronic systems and are identified when inputting information.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider had not ensured staff consistently involved patients in care plans and risk assessments. This was a breach of regulation 9

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • The provider had not ensured that staff respected patients' privacy and dignity and had not ensured that staff did not use restrictive practices to manage the ward environments. This was a breach of regulation 10

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not ensured that all ward areas, seclusion rooms and clinic rooms were clean and properly maintained. • The provider had not ensured best practice in relation to the safe storage, audit and administration of medication in line with guidance.

This section is primarily information for the provider

Requirement notices

- The provider had not ensured staff completed robust risk assessments for all patients in a timely manner, and ensured identified patient risks were effectively managed, regularly reviewed and updated following incidents including section 17 leave conditions.
- The provider did not ensure staff secluded patients or recorded seclusion in line with the provider's policy and the Mental Health Act Code of Practice.
- The provider had not ensured patient information about allergies was documented in individual care records.
- The provider had not ensured there were rigorous processes in place to prevent contraband items from entering the ward environments.
- The provider did not have robust plans to manage patients displaying challenging behaviour in upstairs bedroom areas.
- The provider had not ensured all patients on high dosage antipsychotic medication received a regular electrocardiograph in line with national guidance.

This was a breach of regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The provider had not ensured patients were protected from improper treatment. This was a breach of regulation 13

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider had not ensured that equipment, staff alarms, search randomiser and emergency equipment was properly stored, maintained and easily available. • The provider had not ensured all staff consistently followed the provider's policy about testing and resetting alarms on the wards. This was a breach of regulation 15

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not rectified all the issues raised in the last investigation report in February 2018. • The provider had not ensured that an effective system was in place to record, action and monitor that all maintenance issues were highlighted and resolved in a timely manner. • The provider had not ensured it had processes in place to identify poor quality care, such as using keys to encourage patients to get dressed, and ensure they were dealt with promptly. This was a breach of regulation 17

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had not ensured staffing levels were sufficient to ensure that patients had access to the whole ward. This was a breach of regulation 18