Partnerships in Care Limited

Stockton Hall

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as requires improvement because:

- Some ward areas were not well maintained, well-furnished or fit for purpose. The condition of the wards was not conducive to a therapeutic environment for patients. Most wards had areas requiring updating and furniture that required replacement. The alarm system on most wards was too sensitive, resulting in false alarms.

- Some seclusion rooms were not fit for purpose. Five out of 9 seclusion rooms we looked at still had no en-suite facilities, so patients had to wait for staff members to take them to an adjacent toilet room. Staff had offered bed pans to patients on Kyme ward or to high-risk patients who could not be taken to an adjacent toilet. Damage incurred to the seclusion room on Kyme ward two weeks prior to our visit, however, we were shown evidence that parts and materials had been ordered to enable the necessary repairs to be completed by the end of July 2023. On Dalby and Kyme wards, there was a lack of natural light in the seclusion rooms and the intercom system on Stonegate ward was faulty.

- Clinic rooms were not always fully equipped or well-maintained. A blood monitoring machine on Stonegate ward had not been subject to quality control since September 2018. The medicines trolley on Kyme ward had not been cleaned and there was a spillage in the medicines fridge.

- The service did not have enough nursing and support staff and staff turnover within the service was high. This had led to patients' activities and Section 17 leave being cancelled at short notice.

- The service's medicines management arrangements were not effective. Insulin had not been labelled to show which patient it related to and, 2 glucose tests had expired in July 2022. On Kirby ward, medicine dispensed in the clinic room had been left there unattended.

- There was no evidence of stool monitoring for a patient on clozapine, an antipsychotic medicine known to cause constipation.

- We found issues in 15 out of 19 care records we looked at. These included staff not adequately documenting that patients had access to occupational therapy or psychological input, standard phrases being copied and pasted in care records, out of date or incomplete care plans and no information about 3 patients' strengths.

- Governance structures were not consistently effective. Processes had failed to identify that staff did not always maintain accurate and up-to-date documentation within care records and blanket restriction registers and medicines management was ineffective within the service. There had been insufficient progress in addressing the environmental issues identified in our inspection in January 2020.

- We saw 2 instances in which patients underwent a pat-down search with the door wide open which compromised their privacy and dignity.

- There were limits to spiritual, religious, and cultural support for patients. Multi-faith rooms were sparse in the way of materials, there was no chaplain in post and patients were using their prescribed Section 17 leave to access places of worship in the local community.

Summary of findings

- There were blanket restrictions in place on the ward which were unnecessary. Access to the courtyard and outside spaces at night were dependent on specific circumstances at the time and current staffing arrangements. Access to pool rooms, art rooms and group rooms were restricted because the doors were self-closing with automatic locks, so patients needed a staff member to open them. We found the door to the garden area on Kirby ward was locked and the ward manager told us this was because the grass was being cut but this had already been completed.

- The service did not always engage with carers and relatives well. Three out of 5 carers we spoke with said they had to make efforts to get updates from staff; there was a lack of communication, and their calls were not always returned. One carer told us on multiple occasions, that they had turned up at the hospital for pre-arranged visits with their loved one and staff were not aware of this. Two carers said they did not know how to complain.

However, we found the following areas of good practice within the service:

- Staff had the necessary training, skills, and experience to carry out their roles. They were appraised and received supervision. They adhered to the Mental Health Act and Mental Capacity Act, knew how to report incidents, safeguarding concerns and received lessons learned from investigations into these.

- The teams included or had access to a range of specialists required to meet the needs of patients using the service.

- Patients told us staff were kind, caring, helpful and supportive towards them.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Stockton Hall

Stockton Hall is a medium secure hospital within the Priory Group. It provides treatment for people aged 18 or over with mental health problems, personality disorders, autistic spectrum disorders and learning disabilities. The hospital admits patients from across the United Kingdom.

Stockton Hall is registered with the Care Quality Commission to provide the following regulated activities:

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

The hospital had a registered manager and a controlled drugs accountable officer in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have the legal responsibility for the service meeting the requirements of the Health and Social Care Act 2008 and associated regulations. A controlled drugs accountable officer is a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse as required by law.

The service comprised the following wards:

- Hambleton ward, an 8-bed ward for men with mental illness / co-morbidity.
- Fenton ward, an 8-bed ward for men with autism spectrum disorders
- Kyme ward, a 16-bed ward for men with learning disabilities and co-existing mental illness
- Dalby ward, a 16-bed ward for men with mental illness
- Stonegate ward, a 12-bed ward for women with mental illness and/or personality disorders
- Kirby ward, a 24-bed ward for men with mental illness which was due to close in the next couple of weeks after our inspection
- Castlegate ward, a 12-bed ward for men with mental illness and,
- Farndale ward, a 16-bed ward for men with mental illness.

Castlegate and Farndale wards were due to take the patients from Kirby ward once it closed. Since the last inspection, Boston ward, a 24-bed ward for men with mental illness had closed and Stonegate and Castlegate wards had opened.

The service has been inspected by the Care Quality Commission on 6 previous occasions. The last comprehensive inspection took place 21 to 23 January 2020. The service was rated requires improvement overall; requires improvement under the safe and well led key questions and, good under the effective, caring, and responsive key questions. The service did not comply with 3 of the regulations of the Health and Social Care Act (Regulated Activities) 2014 because:

- There were blanket restrictions in place on all wards that were not necessary to prevent, or not a proportionate response to, a risk of harm posed to or by the patients.

(Regulation 13 Safeguarding service users from abuse or improper treatment).

- The service did not evidence that they had appropriately supported patients to attend to their continence needs while in seclusion.

(Regulation 13 Safeguarding service users from abuse or improper treatment).

Summary of this inspection

- Not all premises and equipment were clean, suitable for the purpose for which they are being used or properly maintained.

(Regulation 15 Premises and equipment).

- The governance systems in place did not provide appropriate oversight. The service did not assess, monitor, and improve the quality and safety of the services provided to patients effectively through their auditing processes as there were multiple administrative errors in documentation.

(Regulation 17 Good governance).

We reviewed whether the provider had made the required improvements during this latest inspection.

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?

Our inspection team comprised 4 Care Quality Commission inspectors, an expert by experience, an occupational therapist and 3 nurses. The occupational therapist and nurses were acting as specialist advisors to the Care Quality Commission.

This was an unannounced inspection which meant staff did not know we were coming.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all the wards within the hospital
- spoke with the hospital director, director of clinical services and medical director
- spoke with 20 patients who were using the service and 5 carers
- spoke with 5 ward managers within the hospital
- spoke with 28 staff members including a doctor, a ward clerk, nurses, healthcare assistants and occupational therapists
- spoke with a pharmacist from the external pharmacy service who provided advice and guidance to the service and conducted audits to support its medicines management arrangements
- checked the quality, safety, and cleanliness of the environment of the wards
- looked at the medicines management arrangements within the service, including the quality of the clinic rooms on each ward
- looked at 19 patients' care records and,
- looked at other documentation around the running of the service.

Summary of this inspection

Areas for improvement

- The provider must ensure that all necessary repair works to improve the quality of the environment are completed within reasonable timescales.

  15 (1) (a) (c) (e)

- The provider must ensure that the planned adaptations to seclusion rooms in relation to the provision of en-suite facilities are carried out within reasonable timescales to ensure patients continence needs are met in a dignified way.

  (13) (3) (c)

- The provider must ensure that the hospital's medicines management arrangements are safe and in line with best practice and national guidance.

  12 (2) (g)

- The provider must ensure that clinic rooms are fully equipped; allow enough space for medicines to be prepared, out of date equipment is disposed of and all equipment used to store or prepare medicines is clean.

  12 (2) (d) (e)

- The provider must ensure there are sufficient numbers of permanent staff with the necessary skills and experience within the service; that it continues in its efforts to recruit more staff and takes steps to retain existing staff.

  18 (1)

- The provider must ensure that staff maintain accurate and up-to-date records of all patients within the service.

  17 (2) (c)

- The provider must ensure that it has effective governance structures and processes to provide oversight and assurance of all aspects of service delivery, to be able to identify and improve practice in a timely manner.

  17 (2) (a)

SHOULDS

- The provider should ensure that male patients' Section 17 leave is not cancelled due to there being insufficient levels of male staff to facilitate it.
- The provider should ensure that blanket restrictions on the wards are proportionate to the risks identified and are clear for all staff and patients to understand.
- The provider should ensure that any areas of the wards locked due to works being carried out are re-opened as soon as they are completed.
- The provider should ensure that any blind spots on the wards are mitigated through the use of mirrors and / or closed circuit television.
- The provider should ensure it takes necessary action to enable pool, art, and group rooms to remain unlocked, so patients have unrestricted access to them.
- The provider should ensure that all trip hazards are identified and clearly marked and risks to people with mobility issues are mitigated.

Summary of this inspection

- The provider should ensure that all patients are aware that staff can support them in finding opportunities for education and employment.
- The provider should ensure that all patients have sufficient access to spiritual support for their chosen faith onsite, so that access is not dependent on the patient being prescribed Section 17 leave.
- The provider should ensure that staff carry out all pat-down searches in a way that does not compromise patients' privacy and dignity.
- The provider should ensure that patients have access to regular ward-based, community-bases and individualised therapeutic activities, including weekends and evenings, and that planned activities are not cancelled due to staffing issues on the wards.
- The provider should ensure that all carers know how to make a complaint and, when their loved ones have given consent, are routinely supported, informed, and involved.
- The provider should ensure the hospital's alarm system is fit for purpose so false alarms are minimised to avoid unnecessary disturbance to patients on the wards. It should also act on the recommendation of the National Autistic Society to introduce silenced door closures on the wards for people with autism.
- The provider must ensure that all its seclusion rooms allow patients occupying them to have adequate access to natural light.
- The provider should ensure that all intercom systems used for communicating with patients in seclusion rooms are working properly to allow for effective two-way communication.
- The provider should ensure that all posters and information on patient noticeboards are up to date.
- The provider should ensure all staff on the wards feel supported and listened to by senior managers within the service and are aware of who the speak up guardians are to promote a culture of openness and transparency.
- The provider should continue with its plan to roll out handheld devices and electronic prescribing so that staff can quickly access and update information about patients.
- The provider should consider recruiting a responsible clinician who is a specialist in learning disabilities and autism.
- The provider should consider routinely inviting healthcare assistants to team meetings so they can contribute to conversations about care and treatment and improve their knowledge.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Forensic inpatient or secure wards

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

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

Not all of the wards were safe, clean, well equipped, well furnished, well maintained or fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe by restricting access to certain areas.

The ward complied with the Department of Health guidance by keeping male and female patients on separate wards.

Staff had access to alarms and patients had access to nurse call systems. However, staff alarms went off accidentally on the wards. For example, multiple staff members told us the alarms went off by mistake quite often. We witnessed this during our inspection. We had concerns that false alarms could cause distress to patients with autism as autistic people are sensitive to noise. There was also a potential risk to staff that frequent false alarms could delay responses in an emergency situation. However, a new alarm system had been fitted on Stonegate ward and staff reported this was much better.

On two occasions during our inspection, we raised concerns about hazards in the main hall reception area. There was a shallow step that members of the team tripped over multiple times and, no handrail up the steps from the rear entrance to the reception area which caused difficulties for one inspection team member with mobility issues. However, the provider sent us evidence that these issues had been addressed after our inspection.

Maintenance, cleanliness, and infection control

Ward areas were still not well maintained, well-furnished or fit for purpose. The need to refurbish the wards was identified during our inspection in January 2020 but had still not been completed. The senior management team told us that repair works had been delayed due to the impact of COVID-19 which started soon after the last inspection.

Requires Improvement

Forensic inpatient or secure wards

All wards except Stonegate and Castlegate, which were new, were still in need of refurbishment. For example, the floor covering in a patient's bedroom on Fenton ward was peeling away from the floor. These issues potentially compromised infection prevention control on the wards.

Seclusion room
We looked at 5 of the 9 seclusion rooms within the service.

Not all the seclusion rooms allowed clear observation and two-way communication. The intercom system for the seclusion room on Stonegate ward was faulty, causing it to make a loud screeching sound.

The seclusion room on Kyme ward was damaged at least 2 weeks prior to our inspection. This included damage to the ceiling light, skylight, and toilet flusher in the toilet in an adjacent room. We were shown evidence that parts and materials had been ordered to enable the necessary repairs to be completed by the end of July 2023. There was also a noticeable smell in this seclusion room due to the previous occupant smearing faeces. The provider's risk register stated that this seclusion room was 'not fit for purpose in size' so it was no longer being used.

Three of the 5 wards we looked at did not have a toilet in the seclusion room. This meant patients had to wait for staff members to take them out of the seclusion room and into an adjacent toilet room. The provider's risk register stated that patients on Kyme ward had been offered bed pans or were having to wait for the toilet. The provider also confirmed that patients deemed too high a risk to be transferred from the seclusion room to an adjacent toilet were also given receptacles to use. These issues were identified as a regulatory breach following our inspection in January 2020 and had still not been addressed.

On Dalby and Kyme wards, there was a lack of natural light other than a skylight in the seclusion rooms.

All the seclusion rooms we looked at had a clock.

Clinic room and equipment
Clinic rooms were not always large enough to allow them to be suitably equipped.

There was no seating or examination couch in the clinic room on Dalby ward due to it being small in size, so staff had to examine patients for physical health issues in a separate room off the ward. This clinic room had gloves available in extra-large size only.

The clinic room on Kirby ward had limited space to prepare medicines. However, there was a separate room off the ward where sterile dressings could be applied, or nurses could apply dressings in the patient's bedroom. The ward was also marked for closure and patients were due to be moved to Farndale or Castlegate wards where the clinic rooms were more fit for purpose.

Staff did not always check, maintain, or clean equipment. The medicines trolley on Kyme ward had not been cleaned and there was a spillage in the medicines fridge. There was limescale on the tap in the clinic room on Dalby ward.

The senior management team told us that equipment was calibrated annually and checks of blood monitoring machines were made on a weekly basis. However, a blood monitoring machine on Stonegate ward had not been subject to quality control since September 2018 which meant the weekly checks were not always effective in identifying

equipment needing calibration. This posed a potential risk to 4 patients on the ward who were diabetic and needed to have their blood sugar levels accurately monitored. The senior management team informed us that following the inspection, the blood monitoring machines and quality control calibration fluid to test for high /low glucose levels had been replaced across all wards.

However, the wards had accessible resuscitation equipment and emergency drugs that staff checked regularly.

Safe staffing

The service did not have enough nursing staff. However, staff within the service knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff. At the time of our inspection, vacancy rates stood at 72 whole time equivalent healthcare assistants and 23 whole time equivalent nurses.

Staff turnover was high. The average turnover in the last 12 months was 30%. The hospital director told us during and post Covid, the service lost a number of nursing staff, including registered nurses and healthcare assistants which had been difficult to replace. Exit interviews with staff who had left the service identified common themes which were a wish to work within new community services or for NHS services which had different terms and conditions.

In the last 12 months, 3,313 shifts had been covered by bank or agency staff within the service.

391 vacant shifts were not covered by bank and agency staff. However, ward managers, charge nurses or night service co-ordinators had covered these shifts when required.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Efforts were being made to recruit agency staff as locum staff.

The average sickness absence over the last 12 months within the service was 3.12%.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the patients.

We saw evidence in care records that patients had regular one to one sessions with their named nurse and patients told us they met with their named nurse regularly.

Staff shared key information to keep patients safe when handing over their care to others during ward rounds.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There were onsite medical staff including doctors during the day and an out of hours doctor available during the night.

Requires Improvement

Forensic inpatient or secure wards

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Compliance with mandatory training modules was between 91 and 100%. Required training compliance was between 80 and 100%. Only one module, safeguarding children on the autistic spectrum was low in terms of compliance (78%) but this had only been introduced in February 2023. Staff had been given protected time to complete this module, so compliance was expected to improve soon.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Modules included:

- basic life support
- immediate life support
- deprivation of liberty safeguards
- equality, diversity, and inclusion courses
- fire safety
- handling complaints
- health and safety
- Mental Health Act and Mental Capacity Act
- safeguarding
- autism
- learning disabilities
- management and leadership courses
- positive behaviour support and,
- incident reporting

Managers monitored mandatory training and alerted staff when they needed to update it.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, staff did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery.

Assessment of patient risk

We looked at 19 patients' care records during our inspection.

We saw evidence in patients' care records that staff completed risk assessments for each patient on or soon after admission and these were reviewed regularly and after every incident. Risks included self-harm, suicidal ideation, delusional thoughts, sexualised behaviour, voyeurism, violence and aggression, and non-compliance with medicines.

Staff assessed risk using recognised risk tools. These included the HCR-20 risk assessment tool, regularly used for patients with violent and aggressive behaviours, Risk for Sexual Violence Protocol (RSVP) and the provider's own risk assessment tool which was similar to other tools used within the mental health care sector.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Requires Improvement

Forensic inpatient or secure wards

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff could not observe patients in all parts of the wards due to blind spots. These were not mitigated by mirrors or closed circuit television. However, the senior management team told us that mirrors had been ordered to address this and risk was mitigated through the use of patient observations on the wards.

Patients returning to the hospital following Section 17 leave were made to undergo a pat-down search in a small side room within the security lodge. We saw 2 instances in which patients were searched with the door wide open which compromised the patients' privacy and dignity.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. There were 116 incidences of restraint in the last 12 months, of which, 4 were in the prone position. The highest number of incidences were on Fenton ward (61 instances) and Kirby ward (29 instances). We looked at 4 incidents of restraint within the service and found that de-escalation techniques had been used before the restraint was applied; no injuries were sustained to the patient or staff members and debriefs were offered to the patient and staff members concerned.

Restraint used was of a low level such as re-directing patients to a low-stimulus room.

In the last 12 months, there had been 116 incidents of seclusion within the service. The highest number of instances were on Fenton ward (61 incidents) and Kirby ward (29).

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

The provider's risk register stated that the impending loss of a responsible clinician posed a risk that medic reviews for patients in seclusion may not always be able to be completed in accordance with the Mental Health Act. However, the risk register stated the provider was making efforts to recruit doctors to the service, utilising the on-call system and using agency doctors to mitigate this issue.

The provider told us that long-term segregation had not been used within the service in the last 12 months.

There were blanket restrictions in place which were unnecessary, or unclear. Access to the courtyard and outside spaces at night were dependent on specific circumstances at the time and current staffing arrangements. Access to pool rooms, art rooms and group rooms were restricted because the doors were self-closing with automatic locks, so patients needed a staff member to open them.

There was an entry on the service's blanket restriction register which was unclear. It stated, 'patients have access to the courtyard for a maximum of 4 x 30 mins per day' but this was contradicted by another statement which said, 'there is no limit on the number of escorted or unescorted courtyard leaves per person per day….' We had concerns that these conflicting statements could lead to staff taking an inconsistent approach to patients' requests to access the courtyard area. However, the provider sent us evidence that this issued had been rectified after our inspection. There was out-of-date information about COVID-19 related restrictions on a noticeboard on Kirby ward going back to 2020 which was no longer appropriate and should have been removed.

Requires Improvement

Forensic inpatient or secure wards

There were no incidences of rapid tranquilisation within the service in the last 12 months.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. The average compliance rate for safeguarding training was 95%.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. These visits were planned in advance and held in a room away from the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There had been 51 safeguarding referrals made in the last 12 months.

Managers took part in serious case reviews and made changes based on the outcomes. In the last 12 months, there had been 8 cases which were reviewed under the provider's serious incident procedures. These included cases of self-harm, an attack on a member of staff by a patient and an alarm failure. The hospital director provided information which evidenced changes had been made to address these issues.

Staff access to essential information

Staff did not always have easy access to clinical information. It was not always easy for them to maintain high quality clinical records.

Patients' care records were not always comprehensive or up-to-date. We looked at 19 patients' care records and found issues in relation to 15 of them. These issues included:

- staff not adequately documenting that patients had access to occupational therapy or psychological input within 4 records
- standard phrases being copied and pasted in care records e.g. a keeping well care plan stated 'encourage 'patient name'
- a care record included guidance for staff around wound care for a patient on Kyme ward. However, staff told us this was no longer relevant as there was no wound. This record also stated that the patient should be encouraged to partake in activities (including sports), but they had been restricted to their bed for two months and,
- three care records did not include information about the patients' strengths.

Records were stored securely. Staff were required to use login names and passwords to access the provider's care records system.

However, staff told us that there were not enough computers on the wards which sometimes caused delays in updating patient information. The senior management team confirmed that there were plans to provide staff with hand-held devices and for there to be electronic prescribing to address this.

Patients on the learning disability and autism wards had a grab file profile. The grab file gave staff a snapshot of each person that they could read quickly to develop a basic understanding of each person, including their likes, dislikes, communication and sensory needs and any physical health needs.

Medicines management

Although systems and processes were in place to ensure staff safely recorded, and stored medicines, staff did not always follow these correctly. We found that staff did not always evidence in care records that they regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff did not always complete medicines records correctly. Three prescription charts on Kirby ward did not include evidence that the patients' 'as required' medicines had been reviewed in the last 14 days. The doctor on the ward told us that 'as required' medicines were reviewed in monthly ward rounds, but this was not documented.

We were not assured that staff always reviewed the effects of each patient's medicines on their physical health in accordance with guidance from the National Institute for Health and Care Excellence. There was no evidence of stool monitoring for a patient on clozapine on Dalby ward. Clozapine is an antipsychotic medicine and one of its known side-effects is constipation. We did, however, see evidence in 8 out of 19 patients' care records we looked at that their medicines were being reviewed during monthly ward rounds, including effects on their physical health.

Staff did not always store and manage all medicines safely. On Dalby ward, we found insulin which was not labelled to show to which patient it related. On Fenton ward, the medicines fridge was not locking.

On Stonegate ward, 2 control solutions for glucose tests had expired in July 2022 and January 2023 respectively.

In the clinic room on Kirby ward, we found dispensed medicine on a counter which had been left unattended.

A medicines trolley on Kyme ward had not been cleaned and there was a spillage in the medicines fridge.

Track record on safety

Staff received alerts to improve safety on the wards. For example, during our inspection, staff received an alert about a type of jewellery which concealed a blade inside of which could be used to cause serious harm. The alert asked staff to be aware of any jewellery being worn by patients.

There had been 8 serious incidents within the last 12 months. These included incidents of self-harm which were mitigated by the use of enhanced observations, a nurse call alarm failure which was reported and rectified, a patient absconding from a ward and an assault on a staff member.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. 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 honest information and suitable support.

Requires Improvement

Forensic inpatient or secure wards

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with provider policy.

There had been no never events within the service in the last 12 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. One duty of candour report had been made in relation to a medicines error within the service in the last 12 months.

Managers debriefed and supported staff after any serious incident. The service had implemented a process of an immediate 'hot' debrief and a 'cold' debrief a few days later, following incidents on the wards. This had been introduced as a psychologically based intervention to support staff and patients who were experiencing trauma following incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where appropriate. We reviewed 4 incidents during our inspection and saw evidence that staff had used de-escalation techniques; patient safety meetings were held, 24 and 72 hour investigations were completed, appropriate action was taken, and safeguarding referrals had been made.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Is the service effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Assessing and managing risk to patients and staff

Staff did not always assess the mental health of all patients on admission. They developed individual care plans but did not always review or update them. Care plans did not always reflect patients' assessed needs and were not always personalised, holistic or recovery-orientated.

We looked at 19 patients' care records and found issues in 15 of these.

Staff had not completed a comprehensive mental health assessment of every patient either on admission or soon after. We found no evidence of a comprehensive mental health assessment being carried out on a patient on Kirby ward.

Staff assessed patients' physical health soon after admission to the ward, but they did not always complete regular monitoring of patients' physical health following this. For example, there was no evidence of physical observations being taken for a patient on Dalby ward, despite a keeping healthy plan stating they should be completed twice a day.

Requires Improvement

Forensic inpatient or secure wards

Staff developed a care plan for each patient that met their mental and physical health needs, but care plans were not always personalised, holistic and recovery-orientated. Three patients' care records did not include information about their strengths. Staff had not adequately documented that patients had access to occupational therapy or psychological input within 4 care records.

Staff did not always regularly review or update care plans when patients' needs changed. A care record included guidance for staff around wound care for a patient on Kyme ward. However, staff told us that this was no longer relevant as there was no wound. This record also stated that the patient should be encouraged to partake in activities, including sports, but they had been confined to their bed for two months which meant the care plan did not correlate with the patient's current health status or needs.

Some aspects of care plans had not been fully personalised to reflect the individual needs of each patient. For example, one positive behaviour plan which was only partially completed. A staff member from another ward told us text was often added to care records using 'copy and paste'.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking, and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. These included:

- bespoke treatments such as sexual violence work including stalking assessments
- autism diagnostic observation schedule assessments
- substance misuse work
- work focussed on patients' index offences
- dialectical behaviour therapy
- radically open behaviour therapy
- compassion focused therapy and,
- cognitive analytical therapy.

Staff delivered care in line with best practice and national guidance.

The provider had reviewed the suitability of the environment on Fenton and Kyme wards for autistic people through accreditation with the National Autistic Society who use a set of standards to benchmark the environment and practice on the wards. This benchmarks providers on how they can make environments and their practice more autism friendly.

The most recent assessment from the National Autistic Society showed that the environment and practice fully or mostly met most areas. The environment had been significantly adapted to include a sensory room and bespoke de-escalation area. Autistic people on Fenton ward also had a spacious ward environment. There was appropriate signage throughout the wards so people could find their way around. Staff had consulted with people who use the service over the environment so that any design and adaptations were made taking their feedback into account. The National Autistic Society assessment identified a small number of areas of improvement and the provider had an action plan to address these areas. For example, one area identified and being addressed was silencing all door closures. During our inspection we also found areas for improvement including sensitive staff alarms going off in error at times and doors that banged on occasions.

Requires Improvement

Forensic inpatient or secure wards

People with autism had recent care and treatment reviews which clearly showed that the multidisciplinary staff in the hospital were meeting people's needs. Care and treatment reviews were used to ensure that people with learning disabilities and autistic people receive appropriate care and treatment and staff from the hospital and the local teams work together to discharge people out of hospital as soon as their ready. Three recent care and treatment reviews identified good quality care to people with a learning disability and autistic people with only a very small number of minor concerns on one care and treatment review about pathways in the community which was beyond the full control of the provider.

Staff made sure patients had access to wider services to meet specific physical health care needs These included dentists, GPs, and other primary medical care services. There was a practice nurse within the service who worked daily to meet patients' physical needs and liaised with primary medical services.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff encouraged patients to choose healthier food options, take regular exercise and undergo cancer screening tests.

Staff used technology to support patients. Although the wards did not have wi-fi, patients could access online facilities using computers in the Galtres centre, an onsite facility which included computers and other activities.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. These included audits of safeguarding training, ligatures, supervision, and fire safety.

Managers used results from audits to make improvements. Examples of improvements following audits included:

- an improvement in staff compliance with their safeguarding and fire safety training
- ligature audit forms being reviewed and updated and,
- lessons learned now being included in supervision sessions including those related to patient safety and clinical governance.

Skilled staff to deliver care

Overall, the ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a good range of specialists to meet the needs of the patients on the wards. These included doctors, nurses, healthcare assistants, psychologists, occupational therapists, and primary medical care services. However, there was no doctor who was a specialist in learning disabilities and autism within the service.

Managers ensured staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. This included safeguarding, an introduction to mental health disorders, conflict resolution, breakaway training, infection control, security, fire safety, a tour of the wards and other training modules.

Managers supported staff through regular, constructive appraisals of their work. The compliance rate for staff appraisal was 98%.

Managers supported staff through regular, constructive clinical supervision of their work. The provider stated the compliance rate for clinical supervision was in the high nineties.

Managers made sure staff attended regular team meetings or gave information from those who could not attend. These included monthly ward round meetings and weekly business meetings which were held weekly or fortnightly. Some healthcare assistants told us they were not routinely invited to meetings and said they felt it would be useful to attend them.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Examples included LGBTQ+ champion training, autism, venepuncture, reflective practice, compassion focussed therapy, degrees in mental health, dysphagia, and cognitive analytical therapy.

Managers recognised poor performance, could identify the reasons, and dealt with these. The provider had a performance management system in place which included a process for addressing staff performance issues. Managers could also seek support and guidance from the provider's human resources team.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams and services, both within and outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation and with external agencies and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of our inspection, 92% of staff had completed their Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice from a Mental Health Act administrator. The Mental Health Act administrator also scrutinised Mental Health Act documentation and fed back any findings to the ward teams so they could improve.

Requires Improvement

Forensic inpatient or secure wards

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated them as necessary and recorded it clearly in the patient's notes each time.

The provider did not confirm how many instances of Section 17 leave had been cancelled in the last 12 months due to staff shortages, despite our asking for this information. They confirmed that 3,006 instances of Section 17 leave relating to 64 patients had gone ahead in the last 12 months.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of our inspection, 92% of staff had completed their Mental Capacity Act training.

No deprivations of liberty safeguards applications had been made in the last 12 months.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff had access to support and advice on implementing the Mental Capacity Act and deprivation of liberty safeguards from a Mental Health Act administrator. The service's Mental Health Act administrator scrutinised Mental Capacity Act documentation and fed back any findings to the ward teams so they could improve.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history.

Requires Improvement

Forensic inpatient or secure wards

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion, and support

Staff treated patients with compassion and kindness. Overall, they respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment, or condition.

During our inspection, we saw that most staff were discreet, respectful, and responsive when caring for patients, interacting with them in a kind and caring manner.

However, patients returning to the hospital following Section 17 leave were made to undergo a pat-down search in a small side room within the security lodge and we saw 2 instances in which patients were searched with the door wide open which compromised the patients' privacy and dignity.

Staff supported patients to understand and manage their own care treatment or condition. Staff directed patients to other services and supported them to access those services if they needed help. We saw evidence in care records that patients had been referred to podiatry, directed to services that provided patients with education about their physical healthcare and had supported patients in receiving their COVID-19 vaccines.

We spoke with 20 patients currently using the service. Patients said staff treated them well, were helpful and provided them with support and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. At the time of our inspection, 94% of staff had completed their information governance training.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments.

Requires Improvement

Forensic inpatient or secure wards

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, information was available in different languages and easy-read. Staff could arrange for interpreters and signers to attend the ward when needed.

Staff involved patients in decisions about the service, when appropriate. Patient representatives for each ward were nominated. They met with members of the senior management team to provide feedback about issues on the wards and make suggestions as to how care and treatment could be improved.

Patients could give feedback on the service and their treatment and staff supported them to do this via community meetings, feedback forms and a complaints process.

Staff made sure patients could access advocacy services. Contact details for advocacy services were included on patient noticeboards on the wards.

Involvement of families and carers

Staff did not always inform or involve families and carers appropriately.

We spoke with five patients' carers during our inspection.

Staff did not always support, inform, or involve families or carers. Three carers told us they had to make efforts to get updates from staff; there was a lack of communication, and their calls were not always returned. One carer told us on multiple occasions, that they had turned up at the hospital for pre-arranged visits with their loved one and staff were not aware of this.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients rarely had to stay in hospital when they were well enough to leave.

Bed management

Managers made sure bed occupancy did not go above 95%. At the time of our inspection, the average bed occupancy for the last 12 months was 90%.

Managers regularly reviewed the length of stay for patients to ensure they did not stay longer than they needed to.

In the last 12 months, there had been 10 out of area placements within the service. However, the hospital was commissioned to take patients from the whole of the United Kingdom, so this was to be expected.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned. Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. There had been only 4 delayed discharges in the last 12 months, and these were due to issues with other providers having to prioritise prison referrals/transfers and bed availability.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity, and privacy

Although the design and layout of the wards supported patients' treatment, privacy, and dignity, the condition of the wards were not always conducive to a therapeutic environment for patients. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Patients could make hot drinks and snacks at any time.

The condition of the wards was not conducive to a therapeutic environment for patients. All wards except Stonegate and Castlegate needed repairs or areas requiring updating and furniture on Kirby ward was ripped.

Each patient had their own bedroom, which they could personalise.

Patients had a secure place to store personal possessions, both within their own bedroom and in other secure areas of the ward for which only staff had access to.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms.

The service had quiet areas and a room where patients could meet with visitors or make phone calls in private.

The service had outside space that patients were able to access. However, during our inspection, the door to the garden area on Kirby ward was locked. The ward manager told us this was because the grass was being cut but this had already been completed.

Patients could have snacks and make their own hot drinks independently.

We saw evidence that the service offered a variety of food. Posters on patient noticeboards offered a variety of food including healthy, vegetarian, vegan and Halal options. Out of the 20 patients we spoke with, 5 made negative comments about the quality of the food. One carer told us their loved one referred to the food as 'diabolical'. However, other patients we spoke with said the food was tasty.

Requires Improvement

Forensic inpatient or secure wards

Patients' engagement with the wider community

Not all staff within the service supported patients with activities outside the service, such as work, education, and family relationships.

Patients had access to opportunities for education and work. However, this was not known by all patients across the wards which indicated they were not adequately promoted by staff. Some patients gave examples of undertaking master's degrees, maths, and English courses whereas others knew nothing about the availability of learning opportunities. The senior management team told us that patients could access courses using online facilities and said 1 patient had completed a hygiene course and others were taking driving lessons. There was also an onsite recovery college offering opportunities for patients to develop skills and obtain qualifications.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service did not always meet the needs of patients. Staff helped patients with communication issues but there was some limits in relation to spiritual support for patients.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, their rights and how to complain.

The service could provide people who used the service with information leaflets available in languages and formats that met the needs of the people who used the service.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

There were limits to spiritual, religious, and cultural support available to patients. Not all wards had multi-faith rooms and those that did were sparse in the way of materials. There was no chaplain in post though the provider was making efforts to recruit one. Patients who were prescribed Section 17 leave used it to access places of worship in the local community. However, an Imam regularly visited the service to support Muslim patients.

We saw evidence in care records that patients had access to individualised therapeutic activities. There was an onsite facility where activities such as woodwork and IT facilities could be accessed called the Galtres centre and some patients were able to work in a shop.

We spoke with 20 patients during our inspection. A patient on Kirby ward told us their external vocational activities were often cancelled at short-notice. Two patients on Dalby and Hambleton wards told us there were no or few activities at weekends or on an evening. We saw there was no activities timetable on the noticeboard on Kirby ward and when we questioned this, the staff member nodded and said 'the Galtres centre is closed today too'.

Requires Improvement

Forensic inpatient or secure wards

We spoke with the senior management team at the hospital about comments made by patients about a lack of activities. They gave us examples of community-based activities such as those centred around the Queen's jubilee, sporting events and other festive occasions and a recovery college in the wider community. They also told us funding had been secured for activities co-ordinators and an additional 2 occupational therapists to be recruited to the service which meant activities provision was likely to be increased.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients knew how to complain or raise concerns. Two carers said they did not know how to complain but staff helped 1 of them by sending a feedback form for them to complete.

The service clearly displayed information about how to raise a concern in patient areas. We saw posters on patient noticeboards about how to raise concerns or make complaints both within the service and with the Care Quality Commission and Parliamentary and Health Services Ombudsman.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. In the last 12 months, 14 complaints had been received, of which 2 were upheld and 9 partially upheld. None of these complaints were referred to the Parliamentary and Health Services ombudsman. We reviewed 5 complaints that had been received within the service and found they had been thoroughly investigated and appropriate action had been taken.

Improvements had been made following investigations into complaints. For example, all property belonging to patients was now logged and staff had been asked to use headphones when watching videos on computers.

Staff protected patients who raised concerns or complaints from discrimination and harassment. For example, when a patient had made a complaint against a peer, staff could adjust their observations levels to keep them safe, patients could be moved to an alternative room away from the peer they had made a complaint against, and safeguarding referrals were made to the local authority. Staff also arranged for patients wishing to make a complaint to have an advocate to ensure they were supported by somebody independent from the service.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The service used compliments to learn, celebrate success and improve the quality of care. In the last 12 months, 28 compliments had been received about the service.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

Requires Improvement

Forensic inpatient or secure wards

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. The onsite senior management team had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders had the skills, knowledge, and experience to perform their roles.

Leaders had a good understanding of the services they managed. When we gave the feedback of the issues we found during our inspection, the senior management team were aware of most of these already. Some steps had been taken to start addressing some of the issues, but we had concerns about the length of time it was taking to do so.

Members of the onsite senior management team were visible in the service and approachable for patients and staff. Staff said the director of clinical services was regularly on the wards and the hospital director visited when incidents had been reported by staff or patients. However, staff told us that they rarely saw senior managers from the wider organisation.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider's values were:

- putting people first
- being supportive
- acting with integrity
- striving for excellence and,
- being positive.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. We saw posters promoting the provider's values on the wards.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing during team meetings and supervision and appraisal sessions.

Culture

Staff felt respected, supported, and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected and valued by their line managers. Staff felt positive and proud about working for the provider and their team. However, some staff felt senior managers did not know the extent of the pressures they faced each day. Staff also felt morale was being negatively affected due to staff turnover and other colleagues planning to leave the service.

Staff felt able to raise concerns without fear of retribution. Staff knew how to access the provider's whistle-blowing process. The service had speak up guardians, however, not all staff we spoke with were aware of this.

Managers dealt with poor staff performance when needed and were supported by the provider's performance management system and human resources team in doing so.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Staff received equality and diversity training and the provider had policies relating to equality and diversity.

Staff had access to support for their own physical and emotional health needs. This included an occupational health service, employee assistance programme and the ability to return to work on a phased return if necessary.

The provider recognised staff success within the service through individual and team awards and thank you messages.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively and were not always managed well.

The governance systems and management oversight within the service were not always effective in identifying areas for improvement or actioning them in a timely way.

The environment was in a poor state of repair which was an issue during our previous inspection. Seclusion rooms still did not have an ensuite and this resulted in bed pans being given to patients on Kyme ward or to patients who were too high a risk to be transferred to an adjacent toilet.

The medicines management arrangements within the service were not always safe or effective. Clinic rooms did not include equipment needed to deliver care and staff did not always calibrate equipment available to ensure it was working correctly.

Some blanket restrictions in place were disproportionate, unnecessary, or unclear.

However, staff were trained, supervised, and appraised and patients who spoke with us said staff treated them well. Staff adhered to the Mental Health Act and Mental Capacity Act. They knew how to report incidents, safeguarding concerns and how to handle complaints. They learned from investigations into incidents, complaints, and safeguarding concerns.

Staff within the service managed beds well and planned for discharges when appropriate.

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. Agendas for staff meetings included standing agenda items such as incidents, safeguarding, complaints, and security to ensure necessary information was shared with staff.

Staff had implemented recommendations from reviews of incidents, complaints, and safeguarding alerts at the service level.

Staff undertook or participated in local clinical audits. The audits that had been carried out were sufficient to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams and services, both within and outside of the organisation, to meet the needs of the patients.

Management of risk, issues, and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff had access to the risk register at ward or directorate level. Staff concerns matched those on the risk register.

Staff at ward level could escalate concerns when required.

The service had a business continuity plan which gave advice to staff about processes for dealing with emergencies such as adverse weather conditions, loss of information technology, emergency situations or a flu outbreak.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. However, staff told us that there were not enough computers on the wards which sometimes caused delays in updating patient information. The senior management team confirmed that there were plans to provide staff with hand-held devices and for there to be electronic prescribing to address this.

The information technology infrastructure, including the telephone system, worked well, and helped to improve the quality of care. However, there was no wi-fi on the wards which meant patients needed to be taken to the Galtres centre to access online facilities.

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. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed such as the Care Quality Commission and local authority.

Requires Improvement

Forensic inpatient or secure wards

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff, patients, and carers had access to up-to-date information about the work of the provider and the services they used through the intranet, bulletins, meetings, and newsletters.

Patients and carers had opportunities to give feedback and were involved in decision making about changes to the service. The service had a complaints process and community meetings were held on the wards.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. The provider worked with carers and families to share information and seek feedback. Wards had patients who were representatives for their peers and were able to attend clinical governance meetings to provide feedback and suggestions to senior managers to help improve care and treatment. Senior managers attended meetings with members of the local community to address any concerns they had about the service.

Leaders engaged with external stakeholders. There had been a recent open day on Stonegate ward which was attended by commissioners who were given an opportunity to look around the ward. Staff shared information about the fabric of the building and security arrangements. Managers kept in contact with the local Healthwatch group and the local integrated care board by email.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes during reflective practice, appraisal, and supervision sessions and at team meetings.

Staff had opportunities to participate in research. Completed research included reviewing the transitions of patients between services. This led to recommendations including a working group focussed on how to implement the outcomes within the service.

Staff used quality improvement methods and knew how to apply them. These included:

- the triangulation of data to ensure all incidents, safeguarding concerns and complaints were reviewed and triangulated to identify any themes.
- briefings to provide effective communication and learning on a specific topic within a 7 minute briefing framework
- Your Safety Matters campaign which involved Information and handbooks being developed for patients to explain what keeping safe means; how they will be supported and, included information about their rights and the use of restrictive interventions
- *Patient Safety Incident Response Framework used by* the NHS in relation to responds to patient safety incidents for learning and improvement. The provider had adopted this framework and the service was incorporating this into its patient safety meetings; review of documentation, and management of incidents to allow for thematic reviews rather than focussing purely on individual incidents.
- Learning from STEIS incidents (Transfer of Strategic Executive Information System). This involved maintaining current documentation, 24 and 72 hour reports and team incident review templates, for the reporting of incidents. This source of information on the effectiveness of intelligence systems or processes enabled reviews and evaluations to improve quality assurance and allowed for the rapid sharing of information across the service to avoid repercussion.

Requires Improvement

Forensic inpatient or secure wards

- The service had implemented a process of an immediate 'hot' debrief and a 'cold' debrief a few days later, following incidents on the wards. This had been introduced as a psychologically based intervention to support staff and patients who were experiencing trauma following incidents.

The service was benchmarked against the wider services within the organisation. Benchmarking included comparing performance and outcomes around complaints and management of incidents.

Wards participated in accreditation schemes relevant to the service and learned from them. These included an accreditation in relation to the service's reducing restrictive practices and a National Autistic Society accreditation for the hospital's autism service.

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 17 HSCA (RA) Regulations 2014 Good governance • The governance systems in place did not provide appropriate oversight. The service did not assess, monitor, and improve the quality and safety of the services provided to patients effectively through their auditing processes as there were multiple administrative errors in documentation. These included out-of-date information about current health status; staff not adequately documenting that patients had access to input from occupational therapists or psychologists and no evidence of physical health observations or comprehensive mental health assessments being carried out. **17 (2) (a) (c)**

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 • Nursing staff vacancies within the service were high. There were 72 healthcare assistant and 23 nurse vacancies within the service. Staff turnover was high. Thirty per cent of staff had left the service in the last 12 months. **18 (1)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	• Insulin was not labelled to show to which patient it related. A medicines fridge was not locking, and a sharps cupboard was unlocked. Tests used for measuring glucose levels and sterile eye pads had expired and a blood monitoring machine had not been calibrated. Medicine had been dispensed and left unattended. A medicines trolley had not been cleaned and there was a spillage in a medicines fridge. **12 (2) (d) (e) (g)**

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 Some seclusion rooms were not fit for purpose. Five out of 9 seclusion rooms we looked at still had no en-suite facilities, so patients had to wait for staff members to take them to an adjacent toilet room. Staff had offered bed pans to patients on Kyme ward or to high-risk patients who could not be taken to an adjacent toilet. **(13) (3) (c)**

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 • Some ward areas were not well maintained, well-furnished or fit for purpose. The condition of the wards was not conducive to a therapeutic environment for patients. Most wards had areas requiring updating and furniture that required replacement. **15 (1) (a) (c) (e)**