Cheswold Park Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated this location as requires improvement because:

- For patients who lacked mental capacity to make key decisions about their care or other aspects of their life, staff did not follow best interest decision-making processes.
- Staff did not always ensure the needs of gay and transgendered patients were fully met and did not access specialist support to enable them to work effectively with patients with these needs.
- The provider's resuscitation procedures and response times did not meet national guidance.
- Staff did not document the use of mechanical restraint in patient support plans.
- Staff did not carry out risk assessment for patients with mobility needs.
- Some of the patient records we looked at did not identify all the pertinent risks. There were some inconsistencies between risks identified in the patient's health action plan and their risk assessment.
- Some of the hospital's policies did not provide staff with the standards expected of them.
- The hospital's procedures did not always identify when staff missed safety checks on equipment.
- The hospital did not do everything it could to protect patients' privacy and dignity when using communal bathrooms.

However:

- The hospital had carried out the actions we told them they must at our last comprehensive inspection.
- The hospital had an effective cleaning schedule in place and staff had received training from the British Institute of Cleaning Science.
- Staff were up-to date with their mandatory training.
- The hospital carried out physical health checks and on-going monitoring with all patients.
- Managers provided staff with supervision and appraisal.
- Overall, patients and carers thought staff were caring and respectful.
- Patients had access to advocacy and knew how to make a complaint.
- Patients had access to a range of activities and a college aimed at promoting recovery
- Staff worked alongside patients to reduce restrictive practices across the hospital.
- Managers and members of the multidisciplinary team participated in monthly governance meetings to improve quality and safety.

Summary of findings

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Requires improvement

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Services we looked at:
Forensic inpatient/secure wards;

Summary of this inspection

Background to Cheswold Park Hospital

Cheswold Park Hospital is a purpose-built hospital in Doncaster. Riverside Healthcare Limited is the provider. The hospital provides low and medium secure accommodation for men over 18, with mental disorders and learning disabilities with an offending background, who require assessment, treatment and rehabilitation within a secure environment. The hospital has the capacity to provide care and treatment for up to 109 patients detained under the Mental Health Act.

The hospital is registered with the Care Quality Commission to provide the following regulated activities:

• Diagnostic and screening, assessment

• Medical treatment of persons detained under the Mental Health Act 1983

• Treatment for disease, disorder or injury.

The hospital does not currently have a registered manager; the previous registered manager left in October 2017 but one of the senior management team had put an application forward to become the registered manager. This was in the process of being assessed when we carried out the inspection. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations. The hospital had a controlled drugs accountable officer on site. Controlled drugs accountable officers are responsible for all aspects of controlled drugs management within their organisation.

The hospital has three medium secure wards, five low secure wards, an autism spectrum condition ward and one long-term segregation suite.

The wards are:

- Aire - 12-bed low secure mental illness assessment
- Brook -15-bed medium secure mental illness/ personality disorder
- Calder - 16-bed low secure personality disorder rehabilitation
- Don - 12-bed low secure personality disorder assessment
- Esk - 12-bed low secure mental illness
- Foss - 12-bed low secure mental illness
- Gill - 12-bed medium secure learning disability
- Hebble - 12-bed medium secure learning disability
- Wilton - five-beds for patients with autism spectrum condition
- Isle suite - one bed long-term segregation suite

We last carried out a comprehensive inspection of Cheswold Park Hospital in February 2017. At that inspection, we rated it as inadequate overall; with safe and well led as inadequate, and effective, caring and responsive as requires improvement. Following that inspection, the hospital was placed in special measures. We carried out a focussed inspection in May 2017 on the care of the patient on the Isle Suite. You can find a copy of that report on our website. We did not at that time review the outstanding requirement notices and the hospital remained in special measures.

At the comprehensive inspection in February 2017, we found that the hospital was not meeting all of the Health and Social Care Act (Regulated Activities) Regulations 2014. We issued the provider with eight requirement notices, which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 HSCA (RA) Regulations 2014. Person-centred care. More than half of care plans reviewed did not contain the patients' views or show evidence of patient involvement.
- Regulation 11 HSCA (RA) Regulations 2014. Need for consent. One patient's care and treatment records did not contain evidence of assessments of Mental Capacity for decisions that did not form part of their detention under the Mental Health Act 1983.
- Regulation 12 HSCA (RA) Regulations 2014. Safe care and treatment. Staff did not follow procedures in place for the safe and proper medicines management. They had also not ensured that all electrical equipment was tested and first aid boxes were regularly checked. Staff did not follow procedures to monitor the physical health of patients. The system in use did not identify shortfalls in physical health monitoring. Care plans did not contain sufficient information regarding identified physical health needs. Patients' risk assessments did

Summary of this inspection

not contain information to show how staff managed and mitigated patient risk. Patients' self-medicating did not have a risk assessment in place. The provider had not increased the ability for staff to see patients in their bedrooms at night. Staff did not always follow the provider's observation policy.

- Regulation 13 HSCA (RA) Regulations 2014. Safeguarding service users from abuse and improper treatment because Brook and Don wards had set shaving times and punitive practice operated on Don ward. Staff exercised control and restraint, which was not always necessary, in response to or proportionate to the risk of harm posed by the patient.
- Regulation 15 HSCA (RA) Regulations 2014. Premises and equipment. Surfaces across the hospital contained debris and the Isle Suite was not regularly cleaned by staff. The Isle Suite was unclean and visibly dirty with stains and residue on the floors and ceilings and brown stains on the ceilings. The Isle Suite was in poor condition with limited furnishings. The suite did not have an intercom system. Communication between staff and patient occurred through a hatch and the door.
- Regulation 17 HSCA (RA) Regulations 2014. Good governance. The provider's systems and processes were not established or effective and did not provide assurance that actions had or had not been completed. Systems and processes did not ensure that staff files had the required relevant qualifications, disclosure and barring service checks and registrations. Staff that investigated serious incidents did not follow the provider's policy. Files did not contain evidence of lessons learned. These documented general investigation findings. Many investigations did not contain any recommendations or action plans.
- Regulation 19 HSCA (RA) Regulations 2014. Fit and proper persons. The provider failed to obtain information that satisfied the requirements of fit and proper persons test prior to the appointment of directors. The provider's records were not up to date and did not show current registrations. This meant that the provider was not aware whether staff had the correct registrations to perform their roles.

At the inspection in February 2017, we also issued a warning notice as the provider was in breach of Regulation 18 (notifications) of the Care Quality Commission (Registration) Regulations 2009. This was because we found that the registered person had failed to carry out their statutory duty to notify the Care Quality Commission of notifiable incidents.

At our comprehensive inspection in February 2017 and our focussed inspection in May 2017, we told the provider it must take the following action to improve the forensic inpatient and secure services provided:

- The provider must ensure that timescales are in place to reduce and remove ligature risks in communal bathrooms.
- The provider must ensure that realistic and achievable timescales are in place for the spy holes in bedroom doors to be removed and replaced with an effective system.
- The provider must ensure that staff understand and are aware of ligature risks in the areas that they work.
- The provider must ensure that ligature audits and risk assessments are accurate, contain risk management plans and actions plans to show how ligature risks are managed and mitigated and any actions required to enable this to be achieved.
- The provider must ensure that all staff complete the observation of patients in their bedrooms consistently and that staff understand what is required of them when undertaking observations.
- The provider must ensure that seclusion suites are maintained and that items that could obscure staff observation are repaired or replaced.
- The provider must ensure that they carry out a risk assessment and staff accurately record emergency and practice drills. These must determine the practicality of emergency medicines reaching patients within the timescales set out in the provider's policy.
- The provider must ensure that all areas of the hospital are cleaned regularly and have an effective cleaning schedule in place.
- The provider must ensure that there is provision made to enable effective hand hygiene for staff working in the Isle Suite.
- The provider must ensure that electrical equipment is tested regularly to ensure that it is safe to use.
- The provider must ensure that regular checks are undertaken to ensure that equipment in first aid boxes is replenished and is fit for use.

Summary of this inspection

- The provider must ensure that all patients' care and treatment records contain a current and regularly reviewed risk assessment and a risk management plan which is sufficient to manage and mitigate patient risk.
- The provider must ensure that the policy on searching provides clarity on what staff responsibility for searching is and the rationale for this and complies with the Mental Health Act Code of Practice.
- The provider must ensure that any restrictions on patients are in relation to clinical decisions based on individual patient risk and are the least restrictive on rights and freedoms.
- The provider must ensure that medication errors are reduced and action is taken appropriately to address medication errors and ensure staff are competent in the safe management and administration of medicines.
- The provider must ensure that there are effective systems in place for the safe and proper management of medicines.
- The provider must ensure that staff carry out a risk assessment and complete a care plan for patients that self-medicate and ensure this is regularly reviewed.
- The provider must ensure that all staff understand and carry out their responsibilities of the duty of candour.
- The provider must ensure that staff follow the provider's policies in relation to the investigation of serious incidents.
- The provider must ensure that statutory notifications to the Care Quality Commission are submitted without delay for the specified occurrences in the Care Quality Commission Registration Regulations 2009.
- The provider must ensure that there is clear communication to staff at all levels about lessons learnt.
- The provider must ensure that an effective system is in place where patients can raise concerns about staff and that action is taken to address concerns raise appropriately by the provider.
- The provider must ensure that staff involve patients and record their views in plans about their care and treatment.
- The provider must ensure that the Isle Suite facilities promote recovery, comfort, dignity and confidentiality of any patient receiving care and treatment in this area.
- The provider must ensure that an effective system is in place that ensures that all staff have the qualifications, competence, skills and experience required to for the work they are employed. This must ensure that staff meet the requirements of the fit and proper persons test and information is sought about staff health.
- The provider must ensure that a robust system is in place to complete the assessment and on-going monitoring of physical health of patients.
- The provider must ensure that patients' care and treatment records contain sufficient information to enable staff to meet their physical health needs.
- The provider must ensure that long-term segregation and the care and treatment of patients in long-term segregation follows the Mental Health Act and Mental Health Act code of practice.
- The provider must ensure that the Mental Capacity Act policy is in line with the Mental Capacity Act and its code of practice.
- The provider must ensure that information in patient care and treatment records can be accessed quickly when needed.
- The provider must ensure that a comprehensive audit programme is in place and that this is completed.
- The provider must ensure that records of meetings are accurate and contain sufficient information to reflect the meeting.
- The provider must ensure that robust and effective governance systems are place to provide assurance and clear responsibility for senior managers within the organisation,
- The provider must ensure that policies are updated in line with organisational change. and areas

We told the provider that it should make the following actions to improve the forensic inpatient and secure services provided:

- The provider should ensure that items that are controlled substances potentially hazardous to health are stored securely.
- The provider should ensure that furniture and fixtures are replaced or repaired when worn or damaged.
- The provider should take steps to reduce the amount of section 17 leave cancelled or postponed due to staffing issues.
- The provider should ensure that where fridge temperatures exceed the recommended range that staff take action to escalate and address this appropriately.

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- The provider should ensure that the needs of patients are taken into account in the mix of male and female staff allocated on shift.
- The provider should ensure that with patient consent that staff involve carers and provide information promptly to both patients and carers to enable their participation and involvement.
- The provider should ensure that staff uphold a patient's privacy when taking medication.
- The provider should ensure that the privacy of any patient using the Isle Suite is upheld when making or receiving telephone calls.
- The provider should ensure that the food provision is reviewed and amended to ensure patients have access to food of good quality, a variety of choice and that food on offer is appropriate to meet all cultural and religious needs.
- The provider should ensure that care plans contain clear and concise information to provide consistent care and treatment to patients.
- The provider should ensure that all staff receive an appraisal of their performance every 12 months.
- The provider should ensure that clinical facilities are used for clinical tasks only.
- The provider should ensure that staff maintain professional boundaries by not allowing inappropriate physical contact including touching between staff and patients.

Our inspection team

Team leader: Liz Mather, Inspector, Care Quality Commission. The team that inspected the service comprised six CQC inspectors and six specialist advisors, including a CQC national professional advisor in learning disability and autism services, a speech and language therapist, three registered mental health and learning disability nurses, and a clinical psychologist.

Why we carried out this inspection

As Cheswold Park Hospital was placed in special measures following our comprehensive inspection in February 2017, we undertook this inspection to see if the hospital had made improvements.

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.

During the inspection visit, the inspection team:

- visited all the wards at the hospital including the Isle Suite
- looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with the chief executive officer and quality assurance and compliance director
- spoke with 36 other staff members including the clinical operations manager, ward managers, deputy ward managers, doctors, nurses, assistant

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practitioners, forensic psychologists, a practice development nurse, social workers, occupational therapists, occupational therapy assistants, senior support workers and support workers
- spoke with 39 patients who were using the service and collected feedback from 11 patients using comment cards
- spoke with five carers and relatives
- attended and observed seven meetings including multi-disciplinary meetings, ward round meetings, handover meetings, community meetings and a restrictive practices meeting.
- looked at 42 care and treatment records of patients
- carried out a specific check of the medication management on all wards
- reviewed six serious incidents, five complaints, and three disciplinary files
- looked at a range of policies, procedures and other documents relating to the running of the hospital.

What people who use the service say

As part of our inspection, we spoke with 39 patients and five carers. We also received feedback from 11 patients using comment cards.

Five carers had only positive experiences to report and one carer had a mixture of positive experiences and some concerns. All the carers we spoke with told us that staff were caring and willing to listen to carers' concerns. One carer reported that the care of their relative had improved a lot since the last comprehensive inspection in February 2017. Carers told us that staff would take any concerns they had seriously and would try to resolve them. However, one carer we spoke with told us staff were not responsive to patient and carer needs; they said that the treatment at the hospital was too focussed on medication.

In general, patients reported that staff were caring approachable and good at their job. Some patients told us a minority of staff were not caring. In general, they told us the hospital was clean and well maintained. Patients said they could personalise their rooms and had access to activities both inside and outside the hospital. Two patients commented that the food was not good but two patients we spoke with said the food had improved. Three patients reported that when the hospital had a 'corridor freeze', for example, when patients were transferred to seclusion, their activity time could be reduced by up to 15 minutes because no-one was allowed to move along the corridors during these times. On Don wards and Calder wards, three patients told us they were disturbed by staff carrying out observations at night. Twelve patients told us they did not think there was always enough staff to allow them to do activities off the wards; they thought this could be because staff were busy observing other patients. Patients told us they knew how to make a complaint if necessary and had access to advocacy services.

In the comment card feedback, five patients said the staff were caring and approachable. One patient commented that the food was bad but another said the food was good. One patient said they had experienced poor care from staff and another said staffing levels could be improved.

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The provider's resuscitation procedures and response times did not meet national guidance.
- Patients were subject to a number of restrictive practices, for example, concerning their personal mail and mobile phone use.
- Staff had not carried out an appropriate risk assessment for patients with mobility needs. They did not carry out a risk assessment in relation to some equipment they used with one patient.
- Some wards did not contain a copy of the provider's ligature risk action plan.
- Some of the patient records we looked at did not identify all the pertinent risks and in some records, we found inconsistencies between the patient's health action plan and their risk assessment.

However:

- The provider had carried out a comprehensive ligature audit on all the wards with a timescale to replace radiators and lighting in patient bedrooms with anti-ligature fittings.
- The hospital had an effective cleaning schedule in place; staff had received guidance and training from the British Institute of Cleaning Science.
- Staff were up-to-date with their mandatory training including safeguarding. They knew how to raise safeguarding alerts.
- Staff were working with patients to reduce restrictive practices.
- The hospital had improved the safe management of medicines and reduced the numbers of medication errors.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The hospital did not have effective arrangements in place to ensure staff acted in line with the Mental Capacity Act.
- For patients who lacked capacity, staff did not carry out best interest decision-making processes properly.
- Staff did not always document in care plans all patients' needs, for example, where they required pain management or assistance with moving around.
- Staff did not always ensure the needs of gay and transgendered patients were fully met.

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- The positive behaviour support plan for the patient in long-term segregation did not demonstrate that staff understood the functions of the patient's behaviours.

However:

- Staff had worked hard to address the issues raised at out last comprehensive inspection.
- The hospital carried out physical health checks and on-going monitoring with all patients.
- Managers provided staff with regular supervision and an annual appraisal
- Patients had access to the full range of mental health disciplines including doctors, occupational therapists, psychologists, social workers, speech and language therapists, nurses and support workers.

Are services caring?

Good

We rated caring as good because:

- Patients were able to get involved in decisions concerning the service and had access to regular community meetings.
- Overall, patients and carers thought staff were caring and respectful and treated patients with kindness and respect.
- Patients and carers were involved in care and treatment plans.
- Patients had access to advocacy, knew how to make a complaint, and could have a copy of their care plans if they wanted them.

Are services responsive?

Good

We rated responsive as good because:

- Staff completed discharge plans with patients and involved where appropriate the person's carer.
- Patients could personalise their bedrooms and had somewhere secure to store their belongings.
- Patients had access to a wide range of equipment and activities aimed at promoting recovery.
- Staff responded to complaints in line with hospital policy and could give examples of improvements they had made.

However:

- The facilities in the Isle Suite were not suitable for the long-term care of patients with learning disabilities or autism.
- Facilities in the communal bathrooms did not ensure patients' privacy and dignity.

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Are services well-led?

Requires improvement 

We rated well-led as requires improvement because:

- The hospital did not have effective arrangements in place to ensure all their policies complied with national guidance.
- Some of the hospital's policies did not provide staff with the standards expected of them.
- The hospital's audit schedule did not identify some gaps when staff did not check equipment in line with hospital policy.

However,

- The hospital had created a number of new posts aimed at ensuring they had effective governance systems in place for staff recruitment, complaints and finances. There were new roles in the quality team and a services director for learning disabilities, autistic spectrum conditions and occupational therapy had been appointed.
- Managers and members of the multidisciplinary team participated in monthly governance meetings and ward managers received regular information about their key performance indicators.
- Staff felt supported by managers and had opportunities for development, team working and mutual support.
- Staff thought the new senior leadership team had made a positive impact on the running of the hospital.
- The hospital took part in quality improvement initiatives and was a member of the Quality Network for Forensic Mental Health Services.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff participated in training in the Mental Health Act and the Mental Health Code of Practice as part of their mandatory training requirements. Staff also had support and guidance from the hospital's Mental Health Act office. Staff told us they reminded patients about their rights every three months and the patients we spoke with confirmed this. Treatment and care records contained valid and up-to-date documentation, which they stored securely.

Staff carried out regular audits section 17 leave forms, informing section 132 rights and other detention documentation. They discussed the results from audits at monthly clinical governance meetings. Mental Health Act office staff were linked into a local mental health legislation group external to hospital and kept up-to-date via internet discussion groups. However, we identified three examples where mental health act documentation relating to medicines needed attention.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act is a piece of legislation which maximises an individual's potential to make decisions for themselves wherever possible. The act and associated code of practice provides guidance and processes to follow where someone is unable to make their own decisions.

The provider had updated their Mental Capacity Act policy in line with the code of practice. The policy contained appendices with forms for recording capacity assessments and best interest decisions. Patient records contained evidence of detailed capacity assessments but we did not see evidence that staff documented best interest decisions where patients' lacked capacity to make decisions. The hospital had provided staff with additional training in the Mental Capacity Act but some staff we spoke with had limited knowledge of best interest decision making and always referred to social work staff, where they had doubts about a patient's capacity to make a decision. We did find evidence that staff supported patients where possible to make their own decisions about treatment and care.

All the patients at the hospital were detained under the Mental Health Act which meant that staff did not provide care and treatment to patients under Deprivation of Liberty Safeguards. We therefore did not inspect the hospital's adherence to this.

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

Cheswold Park Hospital had eight low and medium secure wards of similar design. Each ward had a central nurse's station, which allowed for line of sight over the lounge areas, the bedroom corridors, the communal bathrooms, and other communal spaces outside the clinic rooms. The provider had installed mirrors on some wards to mitigate any areas where staff did not have clear lines of sight and staff completed observations of patients at assessed intervals.

The Wilton ward was accessible through Gill ward and they shared the use of one clinic room located on Gill ward. The Wilton ward was u-shaped in design and had blind spots in the ward area. Staff undertook observations to mitigate the risks from blind spots and had mirrors to enable staff to observe patients in communal areas. This unit also had high ratios of staff to patients.

The Isle Suite was a long-term segregation unit for one patient, which consisted of a lounge, sleeping areas, bathing area and an external secure garden. The suite had a staff observation area with windows, which enabled staff to observe all internal parts of the suite.

Following our last comprehensive inspection, we told the provider they must ensure they had timescales for removing potential ligature anchor points in patient bedrooms, en-suite bathrooms and communal bathrooms. At this inspection, we found the provider had replaced all taps and removed the handrails in patient communal bathrooms on all wards. The hospital had a comprehensive action plan with timescales for the removal of some ligature points in patient en-suite bedrooms. The plan identified that by September 2018, the vanity unit lighting in patients' bedrooms on all wards would be replaced with anti-ligature fittings and the radiator grills with sealed units. When we visited the wards, we could see that some of this work had already begun, for example, on Aire ward, staff had replaced a patient's radiator and lighting in their bedroom.

Each ward had a comprehensive up-to-to-date audit and action plan which identified ligature anchor points in each patient bedroom and the communal areas. The action plan identified actions staff should take to mitigate risks, for example, conduct individual risk assessments to determine observation levels. Each ward manager had copies of the audits, which they showed to us but we could not locate copies of the actions plans on all the wards we visited. This meant that staff might not know what actions the hospital had put in place to mitigate risks. When we spoke with staff, they demonstrated knowledge of the actions they took to mitigate risks in different areas of the ward. Following the inspection, the hospital supplied us with copies of up-to-date ligature risk action plans for all the wards we inspected including the Wilton ward and the Isle Suite.

Following our last comprehensive inspection, we told the provider they must implement an effective system for observing patients in their bedrooms because the spy holes located in the bedroom doors did not allow staff to observe patients properly. At this inspection, we found the provider had installed specially designed anti-ligature vision panels on all patient bedrooms built since 2015. This meant the Wilton ward did not have any spy holes. In rooms without these panels, staff opened patient bedroom

doors to ensure they could observe them properly. The staff we spoke with were clear about what was expected of them when undertaking observations of patients in their bedrooms. Senior support workers and nursing staff assessed the competence of new staff prior to them undertaking observations on their own.

We checked all the clinic rooms located on the wards as well as the physical health suite on the hospital's main corridor. Clinic rooms were fully equipped with a system in place to check emergency drugs. At our previous inspection, we told the provider to ensure they checked first aid boxes and replenish supplies after use. At this inspection, we found the provider had designated staff that regularly checked first aid boxes on all the wards, and implemented a system to ensure supplies were replenished after use.

The supplies of emergency medicines, equipment, oxygen and a defibrillator were held on Aire and Foss wards. This meant that if a medical emergency occurred on another ward, staff would have to transport this equipment quickly between wards. The provider's policy required staff to check the equipment twice per day but when looked at the records for the equipment on Foss ward, we found staff at night had missed the defibrillator and emergency bag equipment on seven occasions during the night shift in February 2018. However, staff had checked the equipment on all occasions during the day shift. At our last comprehensive inspection, we told the provider they must carry out a risk assessment to determine the practicality of emergency medicines reaching patients within the timescales set out in the provider's policy. The provider submitted their resuscitation policy and associated risk assessment. The policy stated that emergency equipment should be available within a reasonable and satisfactory timescale, in response to a 'code blue' medical emergency, for example, when an individual required resuscitation. The provider revised their policy in January 2018 but did not state a timescale for how long it should take staff to transport the equipment to the patient. When we examined records from 3 practice drills, we could not identify in each case how the response time had been calculated or whether the provider considered the response time to be reasonable and satisfactory. Guidance issued by the Resuscitation Council UK states that where patients sustain a cardiac arrest, staff should be able to respond with defibrillation within three minutes of the patient collapsing. The provider could demonstrate that their resuscitation procedures and practice met this requirement. Staff told us the emergency bags were heavy but the provider identified this in their medical emergency risk assessment and they were in the process of sourcing some new ones.

The hospital had three dedicated seclusion suites located away from the wards on the main corridor of the hospital. The 'Jarrow', seclusion suite was clean, well-maintained and in line with the standards outlined in the Mental Health Act code of practice. At the last comprehensive inspection, the other two seclusion suites, Keepmoat and Lakeside, had scratches on the mirrors and observation panels, which could hinder staff observation of patients. At this inspection, we found they had repaired and refurbished these facilities to allow staff clear vision of patients in seclusion. The facilities were also clean and free from stains unlike at our previous inspection, and also now in line with the standards outlined in the Mental Health Act code of practice

At our last comprehensive inspection, we told the provider they must ensure the hospital was cleaned regularly. At this inspection, we found the wards including the Isle suite and Wilton ward had an effective cleaning schedule in place and the ward areas were clean and well maintained. The cleaning schedule demonstrated that staff undertook ad hoc cleaning tasks where required, re-stocked infection control items and identified where refurbishment was required, for example, broken fittings. The hospital had appointed staff that were responsible for hospital cleanliness and they had received training from the British Institute of Cleaning Science. We checked cleaning rotas and found that staff were assigned to clean all areas of the hospital including weekends. They completed a daily infection control log, trained staff in infection control standards and regularly audited cleaning standards on all wards including the Isle Suite.

In response to the issues identified on the Isle Suite at the last inspection, the provider had conducted an infection control risk assessment and installed a sink to enable staff to wash their hands. They implemented a rota for daily cleaning which we checked following inspection. The cleaning records for the Isle Suite for the two months prior to our inspection were complete for both areas of the Suite.

The hospital had a painting schedule in place and had carried out refurbishments such as replacing worn furniture on the wards and repairing the blinds in the Isle suite. When we visited the wards, we could see most of them had

been decorated and repairs had been carried out, for example in patient bedrooms. The hospital carried out environmental risk assessments, which they reviewed annually or earlier as needed. We saw the hospital had recently carried out a fixed wire and portable appliance-testing schedule and staff were in the process of carrying out remedial works. The provider had an up-to-date fire risk assessment, which covered all wards and communal areas.

Reception staff issued all staff and visitors to the ward areas with personal alarms and keys on arrival into the service. Staff wore keys and personal alarms attached by a belt whilst on shift and handed these back to security on exiting the hospital. At each shift, staff from each ward were designated to respond to alarm calls across the hospital. When staff activated an alarm, this notified reception staff as to the location of the alert and they directed the response team to that location. During our inspection, we saw that staff responded promptly when a response was required. All patient bedrooms contained an accessible alarm so patients could alert a nurse or other member of staff if required.

The provider had installed closed circuit television on all wards in communal areas to help them maintain patient and staff safety; they had updated their closed circuit television policy to comply with the latest guidance available from the Information Commissioner's Office.

Safe staffing

The provider had a safe staffing tool, which defined the numbers of nurses, and support workers required each day across the hospital. Staff used the tool to monitor the safe staffing minimum against the actual number of staff used. Each morning staff including senior managers, ward managers and/or deputy ward managers and members of the multi-disciplinary team met to discuss staffing for the coming days. We observed the meeting where we saw how staff discussed staff numbers, skills, and gender mix for each ward. Staff also discussed incidents, new admissions, activities and patient leave which could impact on required staffing levels.

The ward managers told us that if they needed additional staff, they could approach the hospital's resource deployment manager who was responsible for ensuring there were enough staff of the right grade and experience available. Managers had access to bank and agency staff.

Managers confirmed they would use agency staff only as a last resort and would try to use regular agency staff so that patients were familiar with them. Ward managers and deputy managers were surplus to minimum staffing levels but could be included on the nursing rota when required. On the Isle Suite, the hospital had appointed staff to a regular team to oversee the care of the patient in there.

Staffing rotas for the three months prior to our inspection showed that the actual numbers of staff on shift on each ward matched and in some cases, exceeded the hospital's planned staffing levels for that period. In general, managers thought they had enough staff on shift to respond to patient need, however, some staff and patients on Calder, Gill and Brook wards thought they were short-staffed especially at night. Staff on Esk ward told us that other wards sometimes borrowed staff during the day to cover unexpected occurrences on other wards and that this would not show up in main staffing rota. During our inspection, we saw that staff were present in communal areas of the ward at all times.

Most patients confirmed that there were enough staff to enable them to have regular one-to-one time with their named nurse. Patients also confirmed that where agency staff were used, they tended to know the patients and the hospital quite well. Some patients on Gill, Calder and Hebble wards told us sometimes their escorted leave was cancelled because of staff shortages. Information submitted by the provider showed that in the previous six months to February 2018, ten instances of section 17 leave was cancelled due to staff shortages and the highest was on Aire ward. The senior management team told us they had a recruitment strategy in place and anticipated that by the end of March 2018, they would have six nursing staff over and above their establishment levels.

Managers and staff told us they consistently had enough staff to carry out physical interventions in a safe and effective way when required. The hospital had an on-call rota system to enable a doctor to attend to patient in urgent need. The first on call was to one of the speciality doctors with a back-up on call to one of the consultant psychiatrists. Doctors told us they stayed locally when they were on call and could reach the hospital quickly when needed. The hospital also had facilities in case doctors needed to stay overnight. When patients needed to access

emergency services, staff called the local hospital. The provider also had access to vehicles and trained drivers who could transport patients to the local hospital in appropriate circumstances.

All staff had a matrix in place identifying the mandatory training requirements for their role. Mandatory training was delivered mostly by e-learning but staff had to pass a test at the end in order to complete each course. Staff told us if they did not pass the test with an 80% or more score, they had to re-take the course again. Staff confirmed they could be given time off the ward environment as necessary to complete the necessary mandatory training**.** Mandatory training consisted of: hospital security including searching, communication, information governance, duty of candour, safeguarding adults and children, equality and diversity, 'No Force First' including conflict resolution, breakaway techniques, Mental Health Act including Mental Capacity Act, infection control, health and safety, basic or immediate life support, food and nutrition, learning disabilities, autistic spectrum condition, personality disorder, epilepsy, dementia, and asthma. The average current compliance rate for staff across the hospital was 93%. The highest course compliance rate was for duty of candour and the 'No Force First' training at 98%; the lowest was hand hygiene at 87%. All courses exceeded the hospital's compliance targets of either 80% or 90% depending on the course.

Assessing and managing risk to patients and staff

In the six months prior to our inspection, from September 2017 to January 2018, there were 182 incidents of seclusion; these were highest on Brook ward, Gill ward, Hebble and Wilton ward. In the same period there were 250 incidents of restraint; of these, 80 were in the prone position. The episodes of prone restraint were highest on the Wilton ward and the Isle suite. These were significantly higher than the figures reported at the last inspection. When we asked the provider about this, they reported that 80% of the prone restraints were attributable to 3 patients with very complex needs; one of which was discharged to a more appropriate setting during our inspection. One patient required restraint in the prone position on forty-four occasions. The provider reported that the remaining 20% of restraints in the prone position were related to 12 different patients, which was in keeping with previous data. As part of their commissioning for quality and innovation target, the hospital had an action plan to reduce restraint and seclusion. They last reviewed their action pan in January 2018. The action plan stated that staff and patients met regularly to review existing policy and practice including the hospital's blanket restrictions. Patients were involved in delivering training to staff about seclusion and reducing the need for restraint. Staff regularly used a transfer sheet with one patient, which they described as mechanical restraint. They had documented this in the patient's behaviour support plan in line with the requirements of the Mental Health Act Code of Practice.

Information submitted by the provider for the period September 2017 to February 2017 showed that there were 18 episodes of long-term segregation at the hospital in addition to one active episode relating to the Isle Suite, which had commenced in 2014. Of the other 18 episodes, one episode related to one patient and 17 episodes related to one other patient with a learning disability. We reviewed records for the patient with 17 long-term segregation episodes and the average length of each period of segregation was 1.6 days. This showed that staff had tried to end periods of segregation and reintroduce the patient back to the ward environment as soon as possible.

Staff used the Historical Clinical Risk Management 20 and the Functional Analysis of Care Environment risk assessment tools to assess patient risk. During our inspection, we reviewed 42 patients' records and examined risk assessment data for all the patients in the hospital. We found that all except one patients' record contained an up-to-date Historical Clinical Risk Management 20 and a recently reviewed Functional Analysis of Care Environment risk assessment. However, in three of the records we looked at, the risk assessment did not identify all the pertinent risks and in two of the records we looked at, staff had not carried out a risk assessment where patients had mobility needs. According to the Health and Safety Executive two types of risk assessment may be required, a generic assessment for the setting and an individual assessment for the person who needs to be moved or assisted. The hospital did not have a written policy on moving and handling people. With another patient, staff used a transfer sheet to lift them off the ground more than 10 centimetres but the correct use of the sheet did not allow for this. We did not see the hospital had carried out a risk assessment or that they had contacted the manufacturer regarding this practice.

Requires improvement

Forensic inpatient/secure wards

Most staff used the positive behaviour support plan to document risk management actions but in three of the records we looked at the risk management plan was very short and did not identify to staff what they should look for and how to support the patient. We found some inconsistencies between the risks identified in the health action plan and the risks identified in the risk assessment in two of the records we looked at. For example, one patient's health action plan mentioned an allergy the patient had but there was no mention of this on the patient's risk assessment. Since the last comprehensive inspection, we found the provider had made improvements to assessing and managing patient risks including some good examples of comprehensive positive behaviour support plans. However, with a patient in long-term segregation, we did not find evidence that the positive behaviour support plan in place demonstrated that staff understood the functions of the patient's behaviours. This patient was due to be transferred to a different facility more appropriate to their needs.

We saw examples where staff had updated risk assessments following specific incidents but there was an inconsistent approach to how and where in the patient record staff documented risk management plans. Staff told us that daily handover reports only contained information pertaining to the previous 24 hours and staff had to read several reports for information pertaining to the previous 48 or 72 hours. This meant that if a member of staff had not been on duty for two or three days, they would have to read several reports to find out all the risk information, which some staff told us could be cumbersome.

The hospital had an observation policy, updated in January 2018, which stated the minimum observation level for any patient in the hospital was once every 30-60 minutes including through the night. Patients also had more frequent observations if this was identified in their individual risk assessments.

At our last comprehensive inspection in February 2017, we told the provider to ensure that any restrictions on patients were the least restrictive of their rights and freedoms, and, in particular to ensure their search policy complied with the Mental Health Code of Practice. Staff told us they searched all patients on return from leave but the policy was due to change from 1March 2018 so that patients were searched, only in response to an individual risk assessment. The hospital provided us with their new policy, which they developed with patients at a weekly forum aimed at reducing restrictive practices. The new policy stated that staff would only carry out patient searches where they had reasonable grounds to believe that patients had items, which could cause a threat to safety or security. Each search had to be authorised by a nursing manager, unit coordinator or the on-call manager. At the reducing restrictive practice meeting, staff and patients told us the new policy had been agreed and would be implemented the following month.

The hospital had a reducing restrictive practice log, which listed blanket restrictions in place across each ward and across the hospital including the reasons for them. Staff had also carried out an audit checking the practice on the wards in relation to restricted items. The hospital had developed a policy to allow patients access to some restricted items on an individual basis; this was also under discussion by the restrictive practices group. Patients had access to mobile phones if they signed a contract allowing staff to check the contents of their phones including text messages. The policy did not specify the circumstances under which staff would access the contents of patient's phones. Staff issued all patients with the same standard contract. Patients were required to consent to a member of staff being present to supervise them when they opened their mail. If patients did not consent, the policy stated staff could withhold their mail. Patients were not allowed to text each other or to form sexual relationships because of the risk of peer exploitation. These practices were under review at the hospital's reducing restrictive practices group but at the time of our inspection, these policies were still in force. The Mental Health Act Code of Practice states "blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals". These practices applied to all patients on both medium and secure wards. The hospital could not provide evidence that it was necessary to apply these restrictions to all patients.

The hospital had a policy of 'No Force First' which meant staff used restraint only after verbal de-escalation had failed. All staff received bespoke training in an approach aimed at reducing restraint. Staff told us the training was very thorough but it was not specific to patients with a learning disability or autism. We saw some examples where staff showed skills in using verbal de-escalation to calm patients down but some staff were more practiced and skilled at verbal de-escalation than others. Two patients on

Requires improvement

Forensic inpatient/secure wards

Gill ward told us that a member of staff used the withdrawal of leave to manage patient behaviour. When we told the senior management team about this, they immediately took action to investigate the matter, which was still on-going when we left the hospital following our inspection. The hospital had a rapid tranquilisation policy, which they updated in January 2018. In the three months prior to our inspection, the hospital used oral rapid tranquilisation on two occasions.

The provider had a seclusion pack, which contained all the documentation required for the commencement, monitoring and ending of seclusion. Managers audited these records after completion. As part of our inspection, we reviewed a sample of seclusion records and found them to be generally complete and in order. We did note some gaps in recording like missed signatures, times that seclusion had ended and missing nightly observation checks but the quality team had already identified these and circulated a reminder to staff through a monthly lessons learned newsletter.

Staff had completed mandatory training in safeguarding adults and children; training compliance was 97%. The hospital had a social work team with a dedicated safeguarding lead. Staff on the wards could describe different types of abuse and potential indicators of abuse. Support workers told us they would discuss any safeguarding concerns with the nurse in charge and could seek advice from the social work team. Staff had access to an on-line form to report concerns directly to the local authority and all safeguarding incidents were reported through the hospital's incident reporting procedure. The hospital had up-to-date policies on adult and child safeguarding which contained safe procedures for children to visit patients off the ward in dedicated visiting rooms.

At our last inspection in February 2017, we found the hospital did not ensure the safe management and administration of medicines. At this inspection, the hospital had reviewed the medicines management policy in November 2017 to include clear guidance to support the safe self-administration of medicines. Staff carried out an audit in January 2018 found it was fully compliant with the hospital's self-administration of medicines policy.

There was also detailed information for prescribers about how to write prescriptions. A recent audit showed that where staff did not adhere to these in practice, the pharmacist worked with them to support improvement.

The hospital had implemented a new electronic medication system to support medicines stock control and audit. Staff had put appropriate logs in place to record when stock medicines were 'borrowed' from other wards.

We reviewed 72 prescription charts and associated authorities across the hospital. We found these to be clearly presented to show the treatment people had received including relevant details such as, patient allergies. The hospital's audit of medication errors updated in January 2018 showed an 84% reduction in prescription charts errors, a 79% improvement in Mental Health Act prescription errors and a 64% reduction in administration errors, with no 'wrong medicines' errors compared with September 2016. However, on Foss ward, the temperature checks on the medications fridge had not been recorded by night staff on five separate occasions in January 2018; however all the temperatures had been recorded for all the fridges on all the other wards. Appropriate arrangements were in place to supply patients with leave and discharge medicines. However, we identified two examples where Mental Health Act documentation relating to medicines needed attention. This included an overdue Second Opinion Appointed Doctor request for review of treatment (section 61) and a missing section 62 form, for urgent treatment.

Track record on safety

Between March 2017 and February 2018 there were 28 serious incidents, which required investigation. This was less than the 40 reported at our last comprehensive inspection in February 2017. The hospital had updated their serious incident policy to be consistent with guidance issued by NHS England. As part of our inspection, we reviewed four serious incidents and found staff had investigated the incidents in line with their policy and produced a log of lessons learned in each case. During the above period, the hospital reported one death of a patient from an overdose of illicit substances, which they investigated. We saw that staff had made improvements to the patient observation policy and to staff training because of this incident. The hospital commissioned an external provider to carry out a further review of this incident to identify additional learning. This was still on-going at the time of our inspection.

Reporting incidents and learning from when things go wrong

Requires improvement

Forensic inpatient/secure wards

The staff we spoke with had access to the hospital's electronic incident reporting system and could explain what types of incidents they had to report. The hospital's incident reporting policy provided staff with guidance about what incidents to report including restraints, seclusions, medication errors and safeguarding concerns. Managers told us the external review of the death had been commissioned to ensure staff had more opportunities to learn from the incident and receive further guidance in investigating serious incidents.

Ward managers showed us examples of incidents on the live incident reporting system. These incidents had been logged in the daily handover notes. We saw two examples where staff did not report incidents for up to three days; the manager said they would have expected them to report them before this time. However, the hospital's incident and accident reporting policy did not specify a timescale for when incidents not categorised as serious incidents should be reported by staff.

At the last comprehensive inspection, we told the provider they must ensure clear communication to all staff about lessons learned from incidents. At this inspection, staff told us they received a monthly newsletter circulated by the quality team about lessons learned from incidents. We saw a copy of the newsletter from February 2018. It contained a revised protocol advising staff how to respond where they had suspicions about patients taking illicit substances. Managers held fortnightly operational security meetings with other managers to share lessons learned from incidents, which had happened across the hospital. We looked at copies of notes from these meetings and saw a copy of a bulletin, which mangers circulated to staff to remind them about hospital security procedures. Staff told us they discussed lessons learned at team meetings and sometimes in supervision. Staff had opportunities for debrief following incidents which they organised at ward level. Patients could also debrief with staff and the hospital had developed a debrief guide for use with patients.

All the staff we spoke with knew and had received training about the hospital's duty of candour. We saw evidence that staff had written to patients and carers when things went wrong.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

As part of this inspection, we examined 42 patient care and treatment records from across all the wards including the Isle Suite. At our last comprehensive inspection, we identified concerns that staff did not monitor patients' physical health. At this inspection, we found the provider had made improvements by ensuring patients had a health check on admission and on-going physical health monitoring where needed. A GP visited the hospital twice a week to look after patients' physical health conditions. The hospital had recently introduced dedicated clinics for patients taking clozapine and with diabetes. Similar clinics were planned for patients diagnosed with asthma or chronic obstructive pulmonary disease.

Antipsychotic physical health and therapeutic drug monitoring was carried out and recorded when needed. Monitoring is important to ensure people are physically well and that they receive the most benefit from their medicines. Medical staff reviewed patient's physical health every two weeks in their ward rounds. Staff offered patients information about healthier lifestyles and wards had smoking cessation champions to offer patients advice.

Patients who required on-going physical health monitoring had in place a health action plan. However, we found some discrepancies between some care plans and health action plans. For example, in two of the records we looked at there was conflicting information about the patients' health needs between the care plan and the health action plan. This meant that the patient's needs might not be met depending on which document staff looked at.

The majority of care records contained care plans which were personalised and met the needs identified in the assessment. Staff updated care plans regularly and in some records, we found some strong examples of person centred care planning. Although we found some examples of goal orientated care plans, we found some, which had a lack of treatment goals or objectives.

Patients who self-medicated had a care plan in place, which was something we told the hospital to improve last time we carried out a comprehensive inspection. However,

two patients with reduced mobility did not have a specific assessment of their moving and handling needs. This meant the care plan did not identify when and how the patient might need to be assisted to move.

Staff told us that new templates for epilepsy and for diabetes had been developed to improve care planning and were due to be audited from March 2018. However, we found that care plans were not in place for the management of chronic pain. We saw that staff were treating one patient for chronic pain but they had not documented this in the care plan.

We had some concerns that the hospital did not always meet the needs of gay and transgendered patients and that staff did not have access to specialist support to meet the needs of these patients. We saw how one patient did not feel their care plan addressed holistically needs connected with their appearance. One patient told us that they could not hold hands with another male patient. Immediately following our inspection, we raised these issues with the hospital and asked them as a priority to address our concerns.

Patients with complex needs had multiple care plans and some staff told us it could be confusing to know which needs to put in which care plan. We found an example with one patient who had 19 care plans in place. Staff told us the hospital intended to streamline care plans with the introduction of an electronic system. In the meantime, however, staff created care records electronically so they could share them quickly between wards, for example, when patients transferred from one ward to another. Each patient also had a paper file, which staff kept securely in the nurses' station. Although patient records contained a lot of information, it was well organised and put into relevant sections so information could be located easily and quickly.

Best practice in treatment and care

We found evidence that staff followed guidance produced by the National institute for Health and Care Excellence when prescribing medication. For example, staff used validated rating scales to report patient response to treatment and side effects. These included the Liverpool University Neuroleptic Side Effect Rating Scale and Brief Psychiatric Rating Scale.

Patients could access psychological therapies in a group setting or individual sessions. These were mainly cognitive behavioural based therapies which staff adapted for individual patients. Staff told us they delivered dialectical behavioural therapy and schema therapy, which they used to treat patients with personality disorder and other mental health conditions. The therapy team offered patients interventions aimed at improving communication skills, managing anger, building self-esteem, and anxiety management.

The patients we spoke with told us they had participated in, or had been offered access to, psychological therapies. Most patients spoke positively about their experiences and said the therapy had helped them to progress. Staff told us they intended to run a graduate group so patients who had been through the structured group therapy programme could continue to support and mentor each other after the formal therapy programme had ended. Patients had access to a dialectical behaviour therapy helpline run by staff who worked on an on-call rota. Patients could speak to a trained member of staff at any time of the day or night who could help them use the skills they had learned in the therapy sessions.

Patients had access to a GP who held surgeries twice per week at the hospital. The provider also employed two physical health coordinators to facilitate patient access to podiatry, chiropody and physiotherapy. The coordinators worked closely with the hospital's dietician and nutritionist to ensure they met the nutrition and hydration needs of patients. They worked closely with a local dentist and optician. We saw evidence in patient records that staff facilitated good access to healthcare for patients when needed.

Staff told us they used a range of methods to measure outcomes including changes in scoring of functional assessment of care of environments risk assessment, health of the nation outcome scales, pre and post psychometric testing, and the Model of Human Occupation Screening Tool, (MoHOST). Staff on the wards caring for patients with a learning disability or autism told us they planned to use the 'Life Star', an evidence-based tool for supporting and measuring change developed specifically for people with learning disabilities. They told us they had discussed this with the services director newly appointed by the hospital to lead the learning disability and autism service.

Staff participated in clinical audit and gave us examples of audits they had carried out against guidelines provided by

the National Institute for Health and Care Excellence in epilepsy, diabetes, and the management of violence. Clinical staff participated in a national audit of schizophrenia to assess the quality of their prescribing of antipsychotic drugs and the monitoring of patient's physical health. Staff completed an audit in February 2018, which showed full compliance with the hospital's high dose antipsychotic prescribing and monitoring. Staff were due to carry out audits on the recognition and management of depression and high dose antipsychotic therapy and prescribing in learning disability in 2018. The hospital ran an annual programme of clinical seminars and monthly case presentations to promote discussion and review of complex cases.

Skilled staff to deliver care

Patients had access to a multidisciplinary team, which included psychiatrists, doctors, nurses, student nurses, social workers, forensic psychologists, occupational therapists, recovery college teachers, practice nurses, assistant practitioners, and support workers. The hospital also had input from a speech and language therapist, a consultant psychologist and a psychotherapist.

The hospital induction programme consisted of five days of training covering the 15 areas outlined in the Care Certificate standards. New starters had a mentor assigned to them to help them complete a portfolio, which their supervisor assessed at regular intervals throughout their probationary period. The induction checklist on the ward for agency staff did not advise looking at the ligature audits so they knew where the risks were. Managers confirmed they would include this information on the checklist and when they carried out the ward tour with the member of staff.

Staff attended regular team meetings. When staff could not attend, they had access to meeting notes and could speak with ward managers about what staff had discussed. Staff confirmed they had access to regular line management and clinical supervision every six weeks in line with the hospital's supervision policy. Data supplied by the hospital showed that from January to December 2017, the average compliance rate with supervision was 79%. The highest rate was for staff on Calder ward at 94% and the lowest was for staff on Brook ward at 61%. Staff on some wards told us they also had access to group reflective supervision facilitated by the hospital's psychologist. Reflective supervision had recently been introduced but had not yet been implemented across all wards. Managers confirmed they completed staff appraisals annually. The appraisal rate for non-medical staff was at 93%.

Staff had access to training beyond the mandatory requirements. The hospital had a budget for additional training, which staff in the learning and development department administered. Managers ensured that staff had completed all their mandatory training requirements before they allowed them to apply for additional training. Some staff told us they had completed national vocational qualifications in health and social care with support from the hospital. Some staff had undergone their nurse training whilst at the hospital. Staff working on the wards with patients with autism had access to specialist autism training. Supervisors had been trained in supervision skills, which the hospital also allowed non-managerial staff to undertake. Staff told us they had found this training useful and it had improved their knowledge and skills in providing and receiving supervision. The hospital had provided managers with training in root cause analysis, a technique used to investigate serious incidents.

Each ward had staff allocated to key roles as champions. These included a family liaison champion, a patient champion, and a smoking cessation champion. All wards had physical healthcare champions who met regularly to discuss and improve the physical health monitoring on offer to patients. Nurses had access to a six-weekly nursing advisory committee established by the hospital to help qualified nursing staff keep up-to-date and to ensure the hospital was aware of developments in the nursing profession.

The hospital had in place appropriate policies to manage and address poor staff performance. During our inspection, we interviewed the head of the human resources team and looked at a sample of staff personnel files. We found the provider had carried out investigations where necessary and addressed staff performance issues effectively. Documentation in staff files was clear and well ordered. The hospital had clear policies on discipline and grievance procedures.

Multi-disciplinary and inter-agency team work

As part of our inspection, we observed four ward rounds and two multidisciplinary handover meetings. In addition to twice-daily ward handover meetings, staff held a

hospital wide multidisciplinary meeting every morning. Representatives from each ward attended these meetings as well as doctors, occupational therapists, psychologists and members of the senior management team. Staff discussed, incidents from the previous day, patient appointments, patient leave and staffing levels across the hospital. Staff and patients attended multidisciplinary meetings on each ward to discuss patients' care and treatment.

We observed that members of the multidisciplinary team worked effectively together to review patient care and formulate plans. The team knew the patients well and had a good rapport with them.

We saw staff had effective working relationships with external services to support patients' health and social care. For example, staff liaised with social care organisations regarding a patient's arrangements concerning their children. However, we did not see that staff had any access to support to enable them to effectively address the needs of patients who might have gender identity or sexuality issues. Where appropriate, staff from external services and commissioning teams attended care programme approach meetings.

Adherence to the MHA and the MHA Code of Practice

Staff participated in training in the Mental Health Act and the Mental Health Code of Practice as part of their mandatory training requirements. The hospital reported that at the time of our inspection, 95% of staff had completed training. In addition, staff sought support and guidance from the hospital's Mental Health Act office. Staff we spoke with were able to describe blanket restrictions and told us the hospital was reviewing their approach to the use of blanket restrictions.

Patients' care and treatment records contained their section 17 leave forms which described the level of leave and the number of escorts required. The patients we spoke with confirmed that staff informed them of their rights under the Mental Health Act when they were admitted and regularly thereafter. Staff told us they reminded patients about their rights every three months. Treatment and care records contained valid and up-to-date documentation, which they stored securely.

Staff completed audits each month of section 17 leave forms, section 132 rights and other detention documentation. Staff discussed the results from audits at monthly clinical governance meetings. When we reviewed the minutes from these meetings, we could see staff carried out regular audits to ensure the Mental Health Act was being applied correctly. There was evidence that lessons learned were attached to audits and discussed at hospital governance meetings. For example, staff were reminded that a new process was in place so they could quickly check what Mental Health Act documentation should be present in patients' medication files.

Mental Health Act office staff were linked into a local mental health legislation group external to hospital and kept up-to-date via internet discussion groups. However, we identified three examples where mental health act documentation relating to medicines needed attention. This included an overdue Second Opinion Appointed Doctor request for review of treatment (section 61) and a missing section 62 form, for urgent treatment. When we pointed this out to the hospital, they immediately rectified this and submitted the forms.

Good practice in applying the MCA

The Mental Capacity Act is a piece of legislation which maximises an individual's potential to make decisions for themselves wherever possible. The act and associated code of practice provides guidance and processes to follow where someone is unable to make their own decisions.

At our last inspection, we told the provider they must ensure their policy was in line with the Mental Capacity Act and its code of practice. At this inspection, we found they had updated their policy to include lasting power of attorney and appropriate reference to the code of practice. The policy contained appendices with forms for recording capacity assessments and best interest decisions.

The hospital had reviewed their staff training and commissioned additional face-to face-training from an external provider. The hospital reported that at February 2018, 95% of staff had received this training. As part of this inspection, we reviewed the content of the training but found it only provided guidance for staff on assessing mental capacity and not best interest decision making. The Mental Health Act office provided training to staff about best interest decision making but this was only brief. Some staff we spoke with had limited knowledge of best interest decision making and always referred to social work staff, where they had doubts about a patient's capacity to make a decision.

Requires improvement

Forensic inpatient/secure wards

Patient records contained evidence of detailed capacity assessments. For example, in relation to a patient in long-term segregation, we found the care record contained assessments of capacity about physical health care, consent to treatment and access to outside space. However, we did not see evidence that staff documented best interest decisions on four separate occasions where patients lacked capacity. For example, for the patient in long-term segregation, we could find no evidence that any best interest meetings had taken place in relation to the patient's transfer to another facility. When we spoke to staff about this, they told us they had consulted the patient's family about the transfer and they believed it was in the patient's best interest. Staff also discussed the patient's lack of capacity to consent to physical health monitoring but we could find no evidence within the care record that staff had documented a best interest decision-making process. According to the Mental Capacity Act 2005 Code of Practice, staff should make sure a record is kept detailing the process of working out the best interests of a person who lacks capacity.

We found evidence that staff supported patients where possible to make their own decisions about treatment and care. For example, we saw patients had easy read versions of their care plans and staff took time to understand patients' verbal and non-verbal communication.

The provider told us they intended to carry out an audit in March 2018 to find out if staff had an awareness of the statutory principles of the Mental Capacity Act. They also audited the numbers of staff that had participated in mandatory training.

All the patients at the hospital were detained under the Mental Health Act which meant that staff did not provide care and treatment to patients under Deprivation of Liberty Safeguards.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

At our last comprehensive inspection, we had concerns about the professional boundaries of staff because they sometimes displayed tactile behaviour and used inappropriate language. At this inspection, we observed interactions between staff and patients on the ward but we did not find similar concerns. Overall, staff treated patients respectfully and professionally. They provided emotional and practical support when patients approached them. Staff were discrete and we saw they knocked on patient's bedroom doors to ask permission before entering. However, three patients from Don and Calder wards found staff sometimes disturbed them when they carried out observation checks at night.

We received mixed feedback from patients across the wards about how staff treated them but most patients we spoke with told us staff treated them kindly and that they were approachable.

Some patients reported that agency staff did not always have a positive attitude to patients but the provider told us they tried to avoid using agency staff and where possible used their own bank staff instead. Some patients named individual staff and ward managers as providing a caring approach. When we interviewed staff, they demonstrated a caring approach and had detailed knowledge of the individual needs of patients on their ward. However, on Gill ward, two patients told us they had experience a bullying approach from a member of staff. When we spoke with the provider about this, they immediately took appropriate action to investigate it.

In September 2017, the hospital carried out a patient satisfaction survey on all wards. Patients were asked to rate their satisfaction with their ward across a range of different areas including being treated with respect and dignity and involvement in their care. The overall satisfaction rate across the hospital was 65%. The highest patient satisfaction rate was for Foss ward at 85% and the lowest score was for Don ward at 56%.

The involvement of people in the care they receive

Staff took time to get to know patients and orientate them onto the ward and the services, including when they transferred from one ward to another. We saw staff on one ward take time to show a new patient the ward routines and introduce them to staff. They also gave the patient space to get used to their new environment.

At our last comprehensive inspection, we told the hospital they must involve patients and record their views in plans about their care and treatment. In the care plan records we looked at during this inspection, there was evidence that

staff consulted with some patients about their views, but in most cases, patients did not want to engage with their written care plan. We reviewed care plans for 28 patients and found 16 patients were asked but did not want their views recording and declined to engage, 11 patients were consulted and their views were recorded on some care plans, and for two patients we could not see any evidence that they had been consulted or their views recorded. There was evidence that staff routinely offered a copy of care plans to all patients but only a small number of patients had accepted copies. Patients had multiple care plans including positive behaviour support plans and health action plans. Patients we spoke with confirmed that if they wanted copies of any or all of their care plans, they could have them. Some staff working with patients with learning disabilities and autism used a tool called 'the life star' to encourage patients to engage with their care plans.

We saw evidence at multidisciplinary care plan reviews meetings that patients were engaged and staff encouraged them to be actively involved in assessing their risks and planning short-term goals. We attended several multidisciplinary care plan review meetings and found evidence that staff encouraged patients to express their views and take actions to maintain their independence. For example, we observed where one patient contributed to assessing their own risks of offending and staff sought their views on the plan of care with regard to their use of section 17 leave.

Patients told us they had regular access to advocacy services and advocates visited the wards on a regular basis. Wards displayed information on local advocacy services.

Patients told us their carers or relatives could visit them. As part of this inspection, we spoke with six carers of patients currently at the hospital. Five carers had only positive experiences to report and one carer had a mixture of positive experiences and some concerns. Carers commented that staff were caring and willing to listen to carers' concerns. One carer had attended an open day were they had the chance to meet with other carers and ask questions about care and treatment at the hospital. Another carer told us they had a visit from the hospital's social worker when their relative was first admitted and they valued this. One carer told us that since the last comprehensive inspection, care had improved. They told us they had more opportunities to be involved in the care and attended regular care programme approach meetings.

All the carers we spoke with told us they knew how to complain and thought staff would take their concerns seriously and try to resolve them. One carer we spoke with told us staff were not responsive to patient and carer needs and that the treatment at the hospital was too focussed on medication. Staff at the hospital told us they had improved their engagement with carers and each ward had a carers champion to promote family and carer involvement. Staff showed us how they had increased the numbers of carers attending quarterly carer's meetings at the hospital.

The hospital had improved opportunities for patients to be more involved in decisions about the service. For example, staff held community meetings on each ward where patients could express their views. Catering staff and the hospital's dietician met with patients each month to listen to their views about the food and involve them in menu planning. The hospital had just started to involve patients in staff recruitment and whilst we were there, we saw a patient had taken part in interviewing prospective staff.

Patients had the opportunity to participate in weekly meetings with staff aimed at reducing restrictive practice. As part of our inspection, we attended this meeting and observed 11 patients from across the hospital working together with staff to reduce restrictive practice. Together with staff, patients had been involved in changing the hospital's practice on self-medication, reducing restraint and seclusion, searching on return from leave and improved access to mobile phones. Patients were involved in co-delivering training for staff around, for example seclusions. Patients had been involved in producing a video for staff to help them understand seclusion from a patient perspective. They had also co-developed an observation review form offering patients and staff clear guidelines on how to reduce the levels of observation.

Some patients in the hospital had an advanced decision in place to refuse life-sustaining treatment. An advance decision can be made by someone who has capacity to refuse treatment at some point in the future when they may lack capacity.

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

Requires improvement

Forensic inpatient/secure wards

Good

Access and discharge

At the time of our inspection, the majority of beds were commissioned by NHS England, except for one patient for whom the clinical commissioning group commissioned their care. Over the previous six months, the hospital reported the average bed occupancy was 83% and no ward had an occupancy rate of more than 85% except the Isle Suite which was an individual unit. The hospital had an admissions and contracts officer to manage contact between commissioners and the staff responsible for admitting patients. Staff planned admissions to the hospital following the hospital's admissions process; they planned routine admissions at appropriate times. This meant there was a bed available on an appropriate ward. Staff did not move patients during admission unless they had a clinical reason.

In the last six months,15 patients had received care from more than one ward during admission. Transfers between wards took place in line with the patient's discharge plans so patients sometimes moved from medium to low secure when the multi-disciplinary team thought this appropriate. We saw an example of a patient who had been transferred from a medium to a low secure ward for other clinical reasons but this had been agreed with the relevant external agencies.

Over the previous year, the hospital had discharged 35 patients and 27 discharges had been delayed. Seven discharges were delayed for reasons connected with the Ministry of Justice, eight were because a suitable community placement could not be found and 12 patients had been accepted by another facility but were awaiting a bed.

Patients had discharge plans in place containing details of future plans and some contained evidence of discussion with the patient's carer or relative. During this inspection, we observed a multi-disciplinary meeting and saw staff discussing with a patient their move to supported accommodation in the community.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a range of facilities to support the delivery of care and treatment including rooms off the ward areas which patients could access at set times. Facilities included an arts and crafts room, a fully equipped occupational therapy kitchen, a shop selling food, toiletries and newspapers, a facility where patients could get a haircut and a multi-faith room. Each ward had newspapers delivered daily. Patients had access to a library, computers, a gymnasium, a coffee shop and an in-door sports hall and outside all-weather sports pitch, a stocked fishing pond and an outdoor horticultural and woodwork area. The hospital had a physical healthcare suite and a room for patients to meet with visitors. Each ward had a secure garden area and laundry facilities.

The hospital was continually reviewing ways to improve and promote patients comfort and dignity, for example sourcing appropriate coat hangers, rather than the cardboard ones for use in patient bedrooms. Seclusion and de-escalation suites had calming murals on the walls and staff were identifying appropriate furniture for use seclusion suites, including ordering soft chairs. Although there had been some improvements to the Isle Suite, including providing the patient with access to outside space, we found the facilities were not suitable for the long-term care of patients with learning disabilities or autism.

Staff completed examinations in the physical healthcare suite or in patient's bedrooms. Patients went to the clinic room for medication but staff offered to administer medication in patients' bedrooms if that is what they preferred.

The doors on the communal bathrooms on most wards had doors which opened outwards onto a main corridor, with no other privacy arrangements in place. This meant that if staff opened the door to check on patients, their privacy and dignity could be compromised. However, no patients or staff had raised this as an issue.

The hospital had two seclusion rooms located next to each other. Some patients told us they could hear noise from the adjacent seclusion room and this sometimes upset them. We saw evidence in seclusion records that one patient's seclusion had been extended because they became upset and disturbed by another patient in the adjacent seclusion suite.

Forensic inpatient/secure wards

All patients had access to a cordless telephone and a room where they could make calls in private. Some patients had access to a mobile phone issued by the hospital, which the multidisciplinary team agreed based on their assessment of the patient and the risks involved.

All wards except the Isle Suite had a kitchen where patients had access to hot drinks and snacks at any time. The patient on the Isle Suite could ask staff to make them drinks or snacks when they required them. Some wards allowed patients to access kitchen facilities freely whilst others allowed patients access under staff supervision. Patients on all wards could have personal belongings in their bedrooms and the hospital had recently extended the number of belongings patients could store in their rooms. We saw that patients could decorate their walls with their own pictures and could choose a colour scheme for one feature wall. We saw an example where a patient had a wall painted in their favourite football team colour. Some patients had access to their own keys to access their bedrooms, which was dependent on individual risk assessment.

Staff provided a range of activities including educational, recreational and sports activities, and independent living skills. The hospital had a recovery college and an occupational therapy timetable. Patients had access to activities on the wards including breakfast clubs, pool and board games. Each ward had an activity room with access to a television and a games console.

Activities provided as part of the activity timetable included basic educational skills, computer skills, cooking, reading, art and crafts, skills, woodwork, creative writing. The recovery college provided patient access to courses linked to national vocational qualifications. The hospital had a band and a football team, which patients could join. The hospital hosted fishing and other sporting competitions with patients from within their own and other hospitals. Patients had access to activities at weekends but these were reduced. Staff told us the hospital intended to extend the range of activities on offer at weekends by utilising occupational therapy assistants. Patients told us they thought the hospital had a good range of activities.

When patients were transferred to seclusion, the hospital sometimes had a 'corridor freeze', which meant neither staff nor patients could access the corridor whilst the patient travelled to the seclusion suite. Some patients told us this meant their time using the facilities, for example the computer room, could be reduced by up to 15 minutes whilst a corridor freeze was in place.

Some patients told us access to activities could be limited if there were not enough staff on hand or if they were all busy observing other patients. Staff carried out an audit of meaningful activity on one ward in the hospital in February 2018. The audit showed that 13 out of 15 patients had been offered more than 25 hours of meaningful activity per week in that month but 2 patients had not. The hospital noted that not all staff were completing activity records but they did not specify what their plan were to improve this. Activities on the Isle Suite had increased since the last inspection; staff were entering the patient's room between 8 and10 times per day.

Some patients had paid jobs in the hospital such as assisting with pond maintenance and serving in the coffee shop. In response to patients' request, the hospital was in the process of creating opportunities for patients to get involved in assisting the occupational therapists. The hospital had extended patient access to the off-ward facilities from 8am until 9pm.

Meeting the needs of all people who use the service

The hospital entrance was elevated from the ground level but patients who required it had access to a lift. Once in the main entrance, the hospital wards were all on the ground level. Patients had access to an occupational therapist to assess any equipment or adaptations they may need. One patient we saw used walking aids and another had access to a stool for the shower.

On some wards, patients had a board where they could choose a picture to represent their mood each day, for example, happy, angry, sad. The hospital had access to a speech and language therapist and two speech and language therapy assistants. They could produce easy-read leaflets on, for example, on the different psychological therapies available, and patients also had access to medicines leaflets in easy read format. Where required, staff confirmed they had access to interpreter services through an external organisation. The hospital told us they could produce leaflets in different languages as required.

Requires improvement

Forensic inpatient/secure wards

Each ward had information displayed to enable patients to understand their rights, as well as information on advocacy services, how to complain and how to contact the Care Quality Commission.

Lunch and evening meals were prepared in the hospital kitchen and delivered in heated trolleys to the wards. There was a selection of hot meals including vegetarian options. The hospital could provide alternative options for patients with special diets, for example, gluten free, low sugar and vegan meals. The hospital had reviewed the patient meal order forms so patients could highlight their preferences to the catering team. This included religious or cultural preferences. We spoke to one patient who confirmed that they were able to specify personal food dislikes so these were not included in the food they ordered. Compared to the last comprehensive inspection, the majority of patients we spoke with commented that the food had improved. Patients had worked with catering staff to develop a menu for use in seclusion. Patients had access to a multi-faith room and a chaplain from a local parish visited the hospital regularly

Listening to and learning from concerns and complaints

Since the last comprehensive inspection in February 2017, the hospital had appointed a full-time coordinator to deal with complaints from patients and their carers. At this inspection, we spoke with the complaints coordinator, reviewed the hospital's complaints policy and a looked at four complaints. From March 2017 to February 2018, the hospital dealt with 104 complaints. Of these, 12 were upheld, 75 were not upheld, and 12 were partially upheld. Two complaints were withdrawn and three were outstanding at the time we inspected the service. During the same period, there were no complaints referred to the Ombudsman. Some patients told us they thought the hospital did not deal with complaints well but our review of complaint files showed that staff had investigated complaints in line with the hospital's policy. One patient showed us copies of letters in response to a complaint and another patient told us they had received compensation for some possessions which had been damaged accidentally.

The staff we spoke with knew about the hospital's complaints procedure and would assist patients to fill out complaint forms if needed. Staff told us they tried to resolve patient complaints informally through community meetings and reducing restrictive practice meetings. Managers confirmed they received feedback on the outcome of complaints affecting their ward and had access to a dashboard showing the numbers of complaints received by the hospital. Staff could give us examples of changes they had made following informal complaints, for example, patients having access to perimeter walks after dusk and being able to access their finances at any time of day.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

Since the last comprehensive inspection in February 2017, the hospital had revised their vision and values. This was to put increase the emphasis on their new vision, which was 'doing good for others by caring for patients and staff'. The values included care, dignity, empathy, person-centred, competence, and teamwork. Some staff told us they had been involved in developing the new values. The senior leadership team shared the hospital's vision and values with all new employees as part of their induction. Staff could give us examples of how they displayed the hospital's values in their day-to-day work with patients. The senior leadership team had developed a set of organisational objectives which were to:

- build on positive change culture and momentum
- open the new autistic spectrum condition beds
- redesign the assistant practitioner programs in conjunction with their Nursing Council
- continue developing a staff welfare program
- deliver effective benefits from doubling the occupational therapy team
- improve the recovery college
- improve patient feedback
- aim for positive staff feedback / surveys.

Staff told us the hospital had plans to strengthen the occupational therapy team, improve the recovery college and develop the assistant practitioner program. Some staff were involved in shaping these improvements. Staff knew who senior managers were and felt they could approach

them if needed. Senior staff visited the wards regularly and some staff told us they had approached the most senior managers personally with ideas about changing the service.

Good governance

After our last comprehensive inspection in February 2017, we told the provider to take a number of actions to improve including ensuring all staff had all the qualifications and skills required for their role, ensuring staff participate in clinical audit and ensuring staff learned from incidents and patient feedback. At this inspection, we found the hospital had appointed to a number of new posts aimed at ensuring effective governance systems were in place. For example, a new recruitment manager, complaints coordinator, an occupational therapy director, a new finance director and new roles within the quality team.

The learning and development team ensured staff completed mandatory training, and participated in regular supervision and appraisals. Staffing rotas showed that the actual numbers of staff on shift on each ward matched and in some cases, exceeded the hospital's planned staffing levels. Managers ensured staffing levels had an additional 22% capacity built in to allow for sickness, training, and attrition.

Senior leaders were able to demonstrate staff had more feedback regarding lessons learned from incidents and patient complaints.

There were also new cleaning schedules in place and a new facilities manager to oversee the hospital's refurbishment programme.

At the last inspection, we told the provider they must ensure more effective governance arrangements were in place. At this inspection, we found the hospital had a monthly governance committee and a set of key performance indicators to monitor the performance of each ward. All members of the multidisciplinary team and all ward managers attended the governance committee. Staff confirmed they received regular reports in the form of a dashboard for the wards they managed. As part of our inspection, we saw managers had access to reports about compliance with staff training, supervision, patient risk assessment and care plans.

The hospital had an audit schedule showing which monthly audits took place including ward based audits and governance audits. Staff on the wards carried out their own audits but their peers from other wards or the members of the quality team also carried some out. Staff could access support from the hospital's quality team for carrying out audits and action plans. However, we found some missing checks to emergency equipment and medication fridge temperatures but we could not see these had been identified by the hospital's audit system.

The hospital's risk register was accessible from the incident reporting system, which managers on the wards could see. They discussed items for the risk register at monthly clinical governance meetings. Some managers told us they had access to admin support but other managers did not.

The hospital had updated many of their operational policies in line with good practice guidelines. For example, the hospital's serious incident policy had been updated in line with guidance from NHS England and managers had provided staff with training in serious incident investigation. However, some polices did not provide staff with the standards expected of them. For example, the resuscitation policy did not specify what timescales staff had to respond to a medical emergency involving the use of the emergency equipment. This meant that when staff carried out practice drills, they could not be sure their response time was in line with the policy. The provider's incident policy did not specify when non-serious incidents had to be reported so staff were not always aware to report them in a timely way. Some policies regarding restrictive practices did not contain guidance for staff on when to carry out specific monitoring. For example, mobile phone policy stated that staff could check the contents of phones including text messages at any time but did not provide any guidance for staff on the circumstances in which they might carry this out The hospital did not have any policies for staff on moving and handling of patients although some patients had mobility needs and used aids to move around.

Leadership, morale and staff engagement

Most of the staff we spoke with at our inspection felt positive about their role and had a sense of job satisfaction. Many staff thought that the new senior leadership team had made a positive difference to the culture of the hospital. Staff felt more empowered and involved in the running of the service. The provider carried out a staff survey in August 2017 which showed that overall, staff

felt proud to work for the hospital and would recommend it as a good place to work. The survey showed that staff felt supported by line managers and that their concerns were taken seriously.

However, 40% of staff asked in the survey did not agree that staff successes were celebrated by the hospital, or that that they felt able to influence how things were done. Staff confirmed they had access to an employee management forum where they were able to meet managers and discuss issues affecting staff, for example, staff morale. Staff could give feedback through operational meetings, team meetings and through the employee management forum. These meetings fed into the hospitals monthly clinical governance meetings

Staff felt able to raise concerns without fear of victimisation and all the staff we spoke with knew the hospital had a whistleblowing process open to them. The hospital reported that since March 2017, they had dealt with one bullying and harassment case.

The provider told us the average sickness and absence rates for 2017 were just over 3% which, was about the same as at the last comprehensive inspection. Staff had access to a confidential counselling and on-site physiotherapy.

Staff had opportunities for leadership development and some staff had progressed to managerial roles within the hospital. Support workers had the opportunity to become senior support workers and study for accredited training programmes. Staff had more opportunities to meet for mutual support, for example, nurses from across the hospital had started to meet regularly and champions from the different wards met to support each other in their role.

Commitment to quality improvement and innovation

The hospital was a member of the Quality Network for Forensic Mental Health for medium secure and low secure services. The hospital had recently undertaken a review and was awaiting the report. The Quality Network for Forensic Mental Health Services Annual Report 2016-2017 cited Cheswold Park Hospital as a good example of how patients and carers were highly involved in governance throughout the service.

The hospital also took part in Commissioning for Quality and Innovation national goals in reducing restrictive practices and in developing the recovery college. The hospital had an action plan to co-produce and co-deliver activities in the recovery college to increase patient engagement and develop more recovery focussed interventions. Staff and patients met regularly and worked together to reduce restrictive interventions across the hospital.

The hospital had a memorandum of understanding with the International Institute of Organisational Psychological Medicine the aim of which was to promote and exchange ideas, theories and to develop the discipline of organisational psychological medicine.

At the time of our inspection, psychology staff at the hospital were engaged in piece of research concerning the relationship between personality types and burnout in forensic psychiatric staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff carry out risk assessments for patient with mobility needs.
- The provider must ensure that response times to emergencies involving resuscitation comply with national guidance.
- The provider must ensure the care and treatment of patients with gender identity and sexuality issues reflects their needs and preferences.
- The provider must ensure they follow procedures outline in the Mental Capacity Act for making and recording best interest decisions where patients lack capacity.
- The provider must ensure any restrictions placed on patients are on the basis of individual patient risk and are the least restrictive on their rights and freedoms.
- The provider must ensure policies and procedures provide staff with the necessary guidance to enable them to monitor and improve the quality and safety of services they provide.

Action the provider SHOULD take to improve

- The provider should ensure they carry out any necessary risk assessments for any equipment they use with patients.
- The provider should ensure staff document patient pain management plans in the appropriate place in the patient record.
- The provider should ensure they continue to review the environment of the Isle Suite and consider whether the facilities are suitable for the long-term care of patients with learning disabilities or autism.
- The providers systems should ensure they identify and rectify any gaps in safety monitoring.
- The provider should ensure that copies of the relevant ligature risk audit plans are available for staff on all wards.
- The provider should ensure they protect patients' privacy and dignity when using the communal bathrooms on the wards.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The care of patients with gender identity or sexuality issues did not reflect their needs and preferences. Regulation 9 (b) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Where patients lacked capacity, staff did not follow the best interest decision- making process as outlined in the Mental Capacity Act 2005. Regulation 11 (1) (3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The provider's resuscitation policy and procedures did not comply with national guidance.

Staff did not carry out risk assessments with patients with mobility needs.

Regulation 12 (1) (2) (a) (f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The hospital had restrictive practices in place, which applied to all patients without individual risk assessments to justify their application. Regulation 13 (1) (4) (b) (c) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Some of the provider's policies did not operate effectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a) (b)