Nottinghamshire Healthcare NHS Foundation Trust

High secure hospitals

Inspection report

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Ratings

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

Our findings

High secure hospitals

Requires Improvement 

We carried out this announced inspection of Rampton Hospital as part of our continual checks on the safety and quality of healthcare services and to check if improvements had been made since our last inspection in November 2019.

Our rating of the hospital improved. We rated it as requires improvement because:

- We rated safe as inadequate and rated effective, caring, responsive and well-led as requires improvement.
- Managers had not ensured that wards had enough nurses since our previous inspection and wards had high vacancy rates. Activity and therapy staff were regularly redeployed to wards, which impacted on patients' ability to access recreational and therapeutic activities.
- The hospital did not have enough staff trained in British Sign Language to meet the needs of deaf patients.
- Staff did not effectively manage patients' access to risk items on Newmarket ward.
- Staff did not effectively identify or record a patient's physical healthcare needs on Canterbury ward. They did not seek timely medical attention for this patient when it was required.
- Staff did not complete seclusion care plans for patients in line with the trust's restrictive practice policy.
- Staff did not always minimise the use of restrictive practices. Staff regularly confined patients to their bedrooms during the day to maintain safety on the wards. This was not carried out in line with trust policy, which only permitted confinement at night time.
- Staff did not always follow good practice with respect to safeguarding. This is what we found at our previous inspection. At this inspection, they did not always report patient- on-patient assaults as safeguarding incidents.
- Staff did not always monitor clinic room and fridge temperatures to ensure that refrigerated medicines were stored safely.
- Staff did not consistently monitor patients' physical health after rapid tranquilisation was used. This is what we found at our previous inspection.
- Managers did not always ensure that these staff received regular supervision and kept up to date with their mandatory training.
- The trust had not ensured that ward teams had access to the full range of specialists required to meet the needs of patients on the wards since our previous inspection. There were no occupational therapists in the women's' service at the time of our inspection.
- Whilst most staff treated patients with compassion and kindness, we reviewed CCTV footage of an incident where a patient appeared to be pushed by one staff member. This incident was not reported by a second staff member who appeared to witness this.
- We observed one occasion where staff did not respect a patient's privacy and dignity whilst using a communal bathroom on Emerald ward.

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- The hospital did not ensure that effective systems and processes were in place to correctly authorise medicines, or to review mail and telephone monitoring arrangements, in line with the Mental Health Act.
- We observed blind spots in the seclusion rooms on Coral and Grampian ward. There was a notice in place to inform staff of the blind spot on Coral ward but not on Grampian ward.

However:

- Most ward environments were clean.
- Staff stored and managed most medicines safely.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- The service was well led and governance processes had improved since our last inspection. Managers had worked to improve the culture of the hospital by completing cultural reviews on several wards.
- Staff understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The culture of the hospital had improved. Newly appointed quality matrons had started to review culture and equality diversity and inclusion. Staff felt valued and supported.

Is the service safe?

Inadequate  

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

Safe and clean care environments

All wards were safe and well equipped. However, one patient's ensuite was not clean and not all ward areas were fit for purpose or well furnished.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Each ward had an up to date environmental and ligature risk assessments in place. These were updated annually, or when the ward environment had been changed. The risk assessments clearly highlighted which areas of the ward were high risk. Outdoor areas, such as ward garden areas were not included in the risk assessments, however patients could not access these areas without staff supervision. We saw that patient doors were designed to prevent holding, barring and locking on all wards we visited. Patient bedrooms were kept locked when patients were not in them and when patients were confined in their bedrooms. Some patients had access to their room keys, depending on their level of risk.

Our findings

Staff could not always observe patients in all parts of the wards. Not all areas of the wards could be observed from the nursing station but staff used observations in those areas to mitigate risk. Closed circuit television was used (CCTV) in patient communal areas, corridors and seclusion rooms. The CCTV in communal areas and corridors was recorded and available for hospital security staff to review, for example to review following specific incidents. Non-recording CCTV was in place in the seclusion rooms and was used to assist staff with completing regular observations of patients when they used the seclusion room.

Staff did regular physical checks of the ward environment. For example, staff were required to complete a regular physical check of the corridors. However, staff told us that their ability to perform these checks safely was sometimes impacted by staffing levels. Three staff members on mental health wards told us that they were supposed to complete corridor checks in pairs but due to low staffing levels they sometimes had to complete these alone.

Each ward manager completed a security checklist at the start of every day and night shift. The checklist included doing a count of sharp objects on the ward such as cutlery and ligature cutters and a patient count. We reviewed the security checklist book on six wards and saw that this was completed at every shift handover.

We saw evidence that relational security was reviewed for each patient at least every six months. The relational security arrangements for some patients was reviewed more frequently than this, for example if there was a change in their level of risk. Relational security is the knowledge and understanding that staff have of patients. An important part of relational security is the ability for staff members to maintain professional boundaries whilst maintaining a therapeutic relationship. Staff understood the importance of relational security. However, staff shortages across the hospital meant that staff were frequently asked to work on different wards. We were concerned that this affected relational security as this resulted in staff working with patients that they did not know well. Five senior members of staff were also concerned about the impact regular ward moves and staff shortages had on relational security. Staff completed incident forms when security procedures were breached.

The ward complied with guidance and there was no mixed sex accommodation.

Staff knew about potential ligature anchor points and mitigated the risks to keep patients safe. Ligature anchor points were clearly identified within the environmental and ligature risk assessment for each ward. Each ligature risk assessment contained photographs of high risk areas of the ward.

Staff had easy access to alarms and there were enough alarms for all staff. Each ward had their own supply of alarms which were kept on permanent charge in the staff offices. There were enough alarms available for all staff on the wards. The alarms were used to seek assistance during incidents and emergencies. Staff could use the alarm to call on staff from neighbouring wards or from across the site, depending on the level of response that was required. Staff told us that other staff responded quickly when alarms were activated. The hospital security team was responsible for the testing and maintenance of the alarms. Alarms on each ward were tested weekly to ensure they were functioning correctly. Alarms that were used in other areas of the hospital site were tested every three months.

Patients had easy access to nurse call systems. Patients had access to call buttons in their bedrooms.

Maintenance, cleanliness and infection control

Most ward areas were clean. The housekeeping team visited the ward every day and completed a monthly cleaning audit of both on and off ward areas. However, we observed that a patients ensuite bathroom was visibly dirty and the

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floor was heavily stained on Newmarket ward. This ensuite had been used by a patient until the day before our visit. Patient bedrooms were not included on the weekly housekeeping cleaning schedule. The ward manager told us that patients on Newmarket were responsible for cleaning their own bedrooms and bathrooms, but we were concerned that staff had not intervened as this ensuite was particularly dirty and could have been a health hazard.

Not all wards were well maintained or fit for purpose. Mental health wards were located in old buildings which were in need of decoration and updating. They lacked natural light and did not aid patients' recovery. Although the majority of patients had access to ensuite bathroom facilities, only four out of ten patient bedrooms on Adwick, a mental health ward, were ensuite. These bedrooms were used by patients who were in long term segregation. All of the other bedrooms on this ward had a toilet and a sink but patients had to share communal bathing facilities. There were four communal bathrooms, two contained a bath and two contained a shower cubicle. The communal bathrooms did not have ligature reduced fixtures or fittings. This was identified within the ward's ligature risk assessment and staff managed the risks by supervising patients in these areas. The ward manager and quality matron had identified the need for all patient bedrooms to have access to an ensuite shower within the ward quality improvement plan, but no date had been set for this to be completed.

Staff followed infection control policy, including handwashing. Personal protective equipment, including aprons, gloves and facemasks were available at entry points to each ward. Masks were compulsory for wards that had patients who were clinically vulnerable to COVID-19, these wards had a notice on the door to inform visitors that they must wear a facemask.

Seclusion room (if present)

Ten out of the 12 seclusion rooms we inspected allowed clear observation and two-way communication. All seclusion rooms had ensuite bathroom facilities. Staff observed patients through a glass pane in the door and a viewing window panel in the ensuite bathroom. Closed circuit television (CCTV) and convex mirrors mitigated blind spots and supported staff to observe all areas of the seclusion room. However, there were no convex mirrors in the ensuite bathrooms on Coral and Grampian ward to mitigate the blind spot and staff had not identified the blind spots on the environmental and ligature risk assessments. Staff told us that they mitigated the blind spots by asking patients to come back into view when they entered the blind spot, or by entering the area to check on the patient. Whilst Coral ward had a notice outside the seclusion room to inform staff of the blind spot and requested that maintenance install a convex mirror to reduce the blind spot in June 2022, Grampian Ward had not taken any action.

Eleven out of the 12 seclusion rooms had a clock that patients could clearly see from their bedroom. However, there was not a clock for the seclusion room on Jade ward, we raised this with the ward manager and a clock was put into the room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Each ward had a stock of emergency medicines which were checked regularly. However, resuscitation equipment was not always checked on Canterbury ward. Records showed that the weekly check had not been completed on seven occasions between 5 June 2022 and 3 September 2022.

Staff had not ensured that they recorded the room and fridge temperatures in clinic rooms to ensure medicines were stored safely. Between June and September 2022 staff had not recorded the clinic room temperature for 21 days on Aintree ward. In the same time period staff had not recorded the fridge temperatures on Aintree for 15 days and Bonnard for 25 days.

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Coral and Emerald wards shared a clinic room. It was not clear which ward had the responsibility for recording the room and fridge temperatures. Between June and September 2022 there were 52 days where staff had not recorded the room temperature. We found that when staff had recorded the temperature it had exceeded 25 degrees and no action had been taken to reduce the temperature in the room. We visited the clinic room and noticed that it felt hot and there was no form of ventilation or air conditioning. The pharmacist told us that staff tried to mitigate the high temperatures by keeping minimal amounts of medicines and rotating stock, however we found that some medicines had been dispensed some time previously.

Between June and July 2022 fridge temperatures recorded for the clinic room used by Coral and Emerald wards exceeded 8 degrees Celsius on 27 occasions. There were 31 gaps in recording during this period. The room temperature monitoring form stated that staff should take action if the room temperature exceeded 25 degrees Celsius, however, staff had not recorded the actions they had taken.

There was an automated temperature monitoring system which notified ward managers when room and fridge temperatures were out of range. However, this was found to be not working on Grampian, Coral, Bonnard and Blake wards at the time of our inspection. Ward managers received an automated email from the temperature monitoring system but it was not clear who would have oversight for this if the ward manager was not on shift.

Safe staffing

The service did not have enough nursing staff, who knew the patients and received basic training to keep people safe from avoidable harm. This was identified as an issue at our last inspection. Staff regularly had to confine patients in their bedrooms during the daytime, and limit their access to activities and leave, due to low staffing levels.

Nursing staff

The service did not have enough nursing and support staff. From March to August 2022 there have been 288 incident reports when wards did not have the required levels of staffing to meet patients' needs. The mental health wards were the most affected by low staffing, with 110 incidents reported. This was followed by the learning disability wards, with 79 incidents reported. However, we saw all care pathways had been impacted by low staffing levels.

Site managers attended a daily demand and capacity meeting to look at staffing levels across the hospital. They regularly reviewed staffing throughout the day and ensured that the highest risk wards had enough staff to maintain patient safety. The hospital had a staffing contingency plan in place which outlined the actions to be taken if staffing shortages exceeded 30% on wards. Actions included redeploying staff, including therapy and education staff, to wards and using daytime confinement on wards. Despite low staffing levels across the hospital, staff were able to attend other wards to respond to emergencies when the alarm was raised and ensured that there were enough staff on each shift to carry out any physical interventions safely.

We reviewed data which showed there had been three occasions between March and August where patients on Aintree ward had been confined to their bedrooms earlier than they should have been. On one occasion, patients were confined in their bedrooms from 4:20pm and were not able to leave their bedrooms until the following morning. Staff and patients told us that due to low staffing levels, patients were sometimes confined in their bedrooms during daytime hours. Whilst patients in high secure hospitals are subject to night time confinement in their bedrooms as part of security procedures, they should not be confined in their bedrooms during the daytime. Two patients on Aintree ward told us about an occasion where they had been confined to their bedrooms at 4pm due to low staffing levels. Two carers of patients on learning disability wards also told us that their family members were often confined in their bedrooms due to low staffing levels.

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Staff used day time confinement as a way to maintain safety and security on wards when there was not enough staff. This meant that patients were not cared for in the least restrictive way. We were concerned about the impact this had on patients' wellbeing. Data provided by the trust showed that there had been 48 occasions across the hospital where patients were confined to their rooms during daytime hours between March and August 2022. Seven of these occurred on Adwick ward. There was one incident on 4 June 2022 where patients on Adwick ward were confined to their bedrooms all day, this meant that some patients were unable to access the communal showers on this day. Patients on Adwick ward were confined in their rooms from 11:30 am on 25 May 2022 and from 4.30pm on 17 June 2022.

Patients in long term segregation were not always able to leave their bedrooms due to low staffing levels. We reviewed incident reports and found there were 81 occasions between 01 September 2021 and 30 March 2022 where patients in long term segregation were unable to have time out of their rooms, due to low staffing levels. Staff and patients told us that patients in long term segregation did not always have access to therapeutic activities. For example, one staff member told us that they could not regularly support a patient in long term segregation to go for a walk outside, as this patient required two staff members to safely do this but they were not always available due to low staffing. Another staff member told us their role was specifically to work with patients in long term segregation but due to low staffing in other areas of the hospital they were often moved to other wards. One patient in long term segregation told us they could not always leave their bedroom due to there not being enough staff on the ward to facilitate this. This was not in line with the Mental Health Act Code of Practice or the trust's long term segregation policy.

The service had high vacancy rates. As of July 2022, that average vacancy rate across Rampton was 10%. The services with the highest vacancy rate was for forensic support services at 29%. The highest ward vacancy rates was for the learning disability wards at 5%. This had increased from 3% in April. The personality disorder service was the only service with no vacancy rates, they had over recruited by 1%.

The service had high rates of bank nurses and nursing assistants. Seventeen per cent of all shifts between 1 May and 31 July 2022 were covered by bank staff. However, this was not enough to ensure that wards had enough staff. For example, despite bank staff cover, 19% of shifts on the learning disability wards and 21% of shifts on the mental health wards were unfilled during this period. All bank staff were regularly employed by Rampton and so they were familiar with the site. The hospital did not use any agency nurses or healthcare assistants.

The service had reducing turnover rates. The average staffing turnover for wards was 1% between February and July 2022. We saw that the turnover rate from hospital management had reduced from 7% in January and 5% in June.

Levels of sickness were high and increasing. Sickness levels had increased from an average of 13% in February to 28% in July. The highest rates of sickness were in the women's service and the lowest were in the medical support services and forensic support services.

Whilst managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift they did not meet the required numbers. Ward managers used the Mental Health Optimal Staffing tool (MHOST) to calculate the number and skill mix of staff needed for each ward. This was completed every six months. Alongside this, managers reviewed staffing on a daily basis and informed the site manager if they were short staffed. However, ward managers could not always adjust staffing levels according to the needs of the patients. Although ward managers could request additional staff from the site managers, their request could not always be fulfilled. We reviewed incident reports from March to August 2022 and saw there were 67 occasions for mental health wards and 45 occasions for learning disability wards where the site manager had been unable to allocate additional staff.

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Managers ensured that there were registered learning disability nurses employed on wards which supported patients with learning disabilities. Seventy five per cent of all nurses in the national learning disability service were registered learning disability nurses. In addition, seven out of 13 (54%) registered nurses on Emerald ward in the women's service were learning disability nurses. Although this ward was not part of the national learning disability service, some patients on this ward had diagnosed learning disabilities.

Patients did not always have regular one to one sessions with their named nurse. We reviewed the number of named nurse sessions that took place for each ward in August 2022. Seventy-five per cent of patients in the women's service received less than two named nurse sessions per month. The most named nurse sessions occurred on mental health wards, with 65% of patients receiving three or more named nurse sessions in this month.

Patients often had their grounds leave or activities cancelled when the service was short staffed. Staff and patients on all wards we visited told us that on and off ward activities were regularly cancelled due to staffing. Each ward had access to a therapy and education centre but both patients and staff told us that they were often unable to attend this as the staff who normally ran activities at these centres were redeployed to work on wards due to low staffing. Between March and August 2022, there were 122 incidents reported where activities and therapeutic sessions were cancelled as therapy and education staff had been redeployed to support wards, due to low staffing levels. Nursing staff on wards told us that they tried to deliver therapy and education sessions but told us they were often limited in what they were able to provide for patients.

Staff had improved how they shared key information to keep patients safe when handing over their care to others since the previous inspection. Staff shared essential information about patients' needs and risks during daily handover meetings.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was one on call doctor on every day and night shift, supported by one on call consultant. Staff at the physical health centre also provided out of hours medical support until 10pm every night and there were plans for this service to become a 24 hour service.

Mandatory training

Whilst the mandatory training programme was comprehensive and met the needs of patients and staff not all staff had completed it or kept up to date with it. The mandatory training programme included courses such as safeguarding, hospital life support, manual handling, information governance, Mental Health Act and Mental Capacity Act training. The overall training compliance rate for information governance training was 77% but only 48% of staff on Cheltenham ward had completed this training. The overall training compliance rate for fire safety was 82% but 8 out of 24 wards had compliance rates of less than 80% and was lowest on Topaz ward at 56%. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received emails to remind them when their training was due.

Assessing and managing risk to patients and staff

Although staff participated in the provider's restrictive interventions reduction programme, they did not always achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff did not always follow best practice in anticipating, de-escalating and managing

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challenging behaviour to reduce the need for seclusion. They did not always monitor the physical health of patients following the use of rapid tranquilisation, this was identified as an issue at our previous inspection. However, staff assessed risks to patients and themselves well and participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 50 care records and saw that staff had completed a risk assessment for each patient when they were admitted and these were updated regularly during regular multidisciplinary team meetings.

Management of patient risk

Staff knew about any risks to each patient. Staff ensured that they shared key information with staff on other wards when patients were moved. For example, we observed that staff shared key information about patient presentation and risk in advance of the patient being transferred from Cheviot to Hambleton ward.

However, staff did not always act to prevent or reduce risks. We reviewed the care records for one patient on Canterbury ward, which identified that the patient had experienced several recent falls. However, staff had not created a falls risk assessment for this patient and there was no information available to inform staff of what they should do to reduce the risk of falls, or how they should respond if the patient were to have a fall. The patient's records indicated that the patient had fallen on 16 September 2022. This had been witnessed by a staff member, the staff member did not seek medical advice or inform a manager of the fall. The physical healthcare team was not informed of the fall until the evening, which meant there was a delay of over seven hours before the patient received medical attention. This incident resulted in the patient having to attend A&E.

Staff did not always follow procedures to minimise risks where they could not easily observe patients. They did not always document that they had carried out patient observations in line with the patient's identified need. We reviewed eight patient observation records on the learning disability wards and found gaps in four of the records. One patient on Kempton ward who was on 30 minute observations had been given a razor in order to shave. Staff had not completed the observation records for two and half hours after the razor had been given. Another patient on Kempton ward should have been observed by staff every 30 minutes but we found a period of three hours and thirty minutes where staff had not recorded that observations had taken place. A third patient on Kempton ward should have been observed by staff every hour but we found that no observations had been recorded for a total of four hours on one day. On Aintree ward, staff were required to observe a patient every hour. We found a period of three hours where staff had not recorded observations had taken place. Although patients did not experience any harm as a result of the missed observations, we were concerned that staff had not maintained patient observations in line with their care plans and had not improved observation practices since our previous inspection.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff completed a monthly rubdown search of each patient, searched their bedrooms and their lockers at least once a month and completed additional random and reactive searches when needed. The security team completed a monthly audit of rub down searches and room searches in all areas of the hospital. Two patient searches per ward were completed as part of the monthly audit. We reviewed audit data from April to July 2022 and found that 100% of the patient searches observed complied with the security standards. The security team also observed a sample of room searches every month to ensure that these complied with security guidelines and policy. Each patient had a security risk assessment and emergency escape procedure in place, which was reviewed regularly.

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Use of restrictive interventions

Levels of restrictive interventions were high. We reviewed restraint data for February 2021 to July 2022. The use of all types of restraint has increased since our last inspection. In this period there were 1012 episodes of restraint. 557 of these episodes occurred in the women's service. Coral ward had the most episodes of restraint during this period (214). Across the site there were 287 episodes of prone restraint, used with 120 patients. 190 of these episodes occurred in the women's service, used with 52 patients.

There were 307 episodes of mechanical restraint, 213 of these occurred on Coral ward. Mechanical restraint involves the use of a specially designed belt or cuff to restrict a person's movement and should only be used in circumstances where patients pose a significant risk to themselves or others. Senior staff at the hospital met every three months to review the use of mechanical restraint. Mechanical restraint was used appropriately. For example, one patient on Coral ward had a detailed mechanical restraint care plan in place which detailed which mechanical restraint device should be used, when staff should use mechanical restraint and what needs to be achieved for mechanical restraint to end. We also reviewed the use of mechanical restraint for a patient on Cheltenham ward. This patient also had a detailed mechanical restraint care plan and the use of mechanical restraint was recorded appropriately in line with the Mental Health Act Code of Practice. We spoke with the patient who understood why mechanical restraint was used and told us that they had been involved in writing their care plan.

Staff understood the Mental Capacity Act definition of restraint and worked within it. During the inspection we observed staff on Coral ward used verbal reassurance to support a patient to have their medication and this meant that restraint did not need to be used.

The use of rapid tranquilisation and seclusion had increased since our last inspection. There were 213 episodes of rapid tranquilisation and 686 episodes of seclusion between February and July 2022. Staff did not always follow National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. This was also an issue at our last inspection. We found that staff did not consistently monitor patients' physical health after rapid tranquilisation was used. For example, we saw that staff administered rapid tranquilisation for one patient on Bonnard ward, the patient was then immediately placed into seclusion on another ward and there was no evidence that their physical health had been monitored. We reviewed 11 episodes of rapid tranquilisation for patients in the women's service and found staff had not completed physical health monitoring for eight of these episodes.

Only 60% of all ward staff had completed the mandatory rapid tranquilisation training course. Rapid tranquilisation was used most frequently in the women's service, 194 out of the 213 episodes of rapid tranquilisation reported between February and July 2022 had occurred on Coral ward. We had requested rapid tranquilisation training data for all wards, but this was not provided for Coral ward. However, we saw that training compliance was below the 80% compliance rate for staff on all of the other women's wards and was lowest for Topaz ward, at 47%.

Staff did not always attempt to avoid using seclusion by using de-escalation techniques and did not only use seclusion when de-escalation had failed. This practice was not in line best practice guidelines. We reviewed CCTV footage of four incidents, on four different wards. The incident reports completed for each of these suggested that staff had tried to de-escalate incidents to reduce the need for seclusion but this was not evident in three of the four incidents we reviewed. For example, we saw that staff immediately escorted a patient to seclusion without engaging in conversation following an incident, despite the incident report suggesting that they had tried to talk to the patient to avoid the need for seclusion.

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We reviewed an incident for one patient on Coral ward, who is deaf. The incident report stated that staff had tried to engage with the patient and offer alternatives to seclusion. However, none of the staff present in the CCTV were trained in British Sign Language, which was the patient's first language. This meant that staff were unable to effectively communicate with them. We noted that most incidents for this patient happened at a time when there was no trained signer on the ward.

Staff and patients did not always have access to clear information about what needed to be achieved for seclusion to end. We reviewed seclusion care records for seven patients. None of these contained a specific seclusion care plan. There was no clear guidance in any of the seclusion records we reviewed about why seclusion should be used, what must be achieved for seclusion to end and what support the patient would need when the seclusion period ended. This is not in line with trust policy which indicates that this information should be included within a specific seclusion care plan for each patient.

When a patient was placed in seclusion, staff kept clear records. We found no gaps in any of the seven seclusion observation records we reviewed and saw that nursing and medical reviews took place regularly, in line with the Mental Health Act Code of Practice.

There were 14 patients in long term segregation at the time of our inspection. Seven of these were on Adwick ward. The recording of long term segregation had improved since our previous inspection. Staff followed best practice guidance, including guidance in the Mental Health Act Code of Practice if a patient was put in long-term segregation. The trust completed a review of all patients in long term segregation every three months. Each of the high secure hospitals in England complete a peer audit of the use of long term segregation every three months. We reviewed the care records for three patients who were nursed in long term segregation and saw that staff had created a long term segregation care plan for each patient. Each patient had an easy read version of the care plan. We saw that staff reviewed each patient regularly. Patient observations and reviews were completed in line with the Mental Health Act Code of Practice. The hospital engaged with the Independent Care (Education) and Treatment Review (ICETR) programme to ensure that patients who were cared for in long term segregation had an independent review of their care.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The trust completed an annual review of restrictive practice and there was an ongoing quality improvement project at the hospital to improve access to debriefs following the use of restrictive practice.

Safeguarding

Safeguarding incidents were not always reported correctly and not all staff had kept up to date with training on how to recognise abuse. Although most staff understood how to protect patients from abuse, we viewed CCTV footage of one incident where a patient appeared to have been pushed by a staff member. This appeared to be witnessed by another staff member who did not report the incident to their manager.

The trust had a safeguarding team, with a single point of access for all services. Rampton hospital has two designated safeguarding leads who are specifically assigned to provide safeguarding advice and support to staff.

Managers had not ensured that staff kept up to date with training on how to recognise and report abuse, appropriate for their role. All nurses and healthcare assistants were required to complete level three safeguarding children and adults training. The overall compliance rate for safeguarding adults level three training was below the trust compliance rate of

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80% for 13 out of 24 wards. Only 55% of staff on Cheltenham ward had completed this training. Eight out of 24 wards had an overall compliance rate of under 80% for safeguarding children level three training. Again, Cheltenham ward had the lowest compliance rate of 63%. Coral ward was the only ward where all nursing staff were up to date with both safeguarding children and adults training.

We were concerned that staff did not always report safeguarding issues in order to maintain the safety of patients. We reviewed CCTV footage of an incident that had occurred on Coral ward. The footage showed that a staff member appeared to push a patient. This appeared to be witnessed by a second staff member but they did not report this to a manager. Managers did not become aware of the incident until CQC inspectors had asked to view the footage. The hospital are investigating the incident, have taken action to support the patient, and have followed their disciplinary procedures with the staff who were involved.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act, this had improved since our last inspection. Staff completed training on equality, diversity and inclusion as part of the hospitals mandatory training programme.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting the ward safe. Social workers had to approve all child visits to the hospital. Children were not allowed to visit patients on wards, instead visits with children took place in designated visiting rooms off the ward.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, staff did not report all patient on patient assaults as safeguarding incidents. We reviewed incident data from February 2022 to August 2022. Within this period 42 patient on patient actual physical assaults were reported as safeguarding incidents, 68 actual assaults were not reported as safeguarding incidents. Staff should record all incidents where a patient has been physically assaulted as safeguarding incidents.

Staff access to essential information

Staff did not always have easy access to clinical information, as staff used different recording systems. It was not always easy for them to maintain high quality clinical records.

Patient notes were comprehensive and all staff could access them easily. Records were stored securely. However, staff on wards and staff in the physical healthcare team used two separate systems to record patient notes. Ward staff depended on physical healthcare staff to add information about patients' physical health needs onto the system that they used.

We saw that ward staff had created one- page profiles for each patient which contained basic information about patients' risks and de-escalation strategies that staff could access at a glance.

Since our last inspection, the trust had introduced an electronic tablet for staff to record patient's prescribed observations.. Staff told us that the tablets were generally easy to use and alerted them to when they needed to complete patient observations. There were enough tablets on the ward for staff to use.

When patients transferred to a new ward, there were no delays in staff accessing their records.

Our findings

Medicines management

The service did not always use systems and processes to safely prescribe, administer, and store medicines. Staff did not always monitor patients' physical health after rapid tranquilisation was used. However, staff stored prescribing documents safely and regularly reviewed the effects of medications on each patient's mental health.

Staff followed systems and processes to prescribe and administer most medicines safely. However, we saw that some patients were prescribed multiple 'when required' medicines to manage violence and aggression, there was no guidance to help staff to know which medicine should be administered. For example, one patient on Coral ward was prescribed three different types of medicines to manage their mental health condition and anxiety but there no guidance contained within their prescription record or care plans to help staff to know the circumstances when the different types of medicines should be used. This was not in line with National Institute for Health and Care Excellence (NICE) guidance, which recommends staff record a clear rationale for using medicines and that patients have a documented, individualised strategy for using 'when required' medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and about their medicines. Staff reviewed patients' medicines at multidisciplinary meetings and ward round meetings. Patients were invited to attend ward round meetings and doctors spoke with patients about their medicines. Pharmacists completed regular reviews of patient prescription charts. Staff told us that they could contact the pharmacist when needed.

Staff completed medicines records accurately and kept them up-to-date. We reviewed 103 prescription charts and found that medicines were generally administered to patients as prescribed. If medicines were not administered as prescribed, staff clearly recorded the reasons for this.

Staff stored and managed most medicines safely. We inspected the clinic rooms on 13 wards and found that most medicines were stored appropriately and were within the manufacturer's expiry dates. However, there were gaps in the fridge and room temperatures for four wards. Fridge temperatures recorded for the clinic room used by Coral and Emerald wards exceeded the maximum temperature of 8 degrees Celsius on 27 occasions during June and July 2022. There were 31 gaps in recording during this period. We saw that the fridge contained insulin for diabetic patients and were concerned that this this was not being stored and managed correctly.

Staff managed prescribing documents safely and stored them securely on the electronic system.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice. Incidents involving medicines were discussed regularly at the trust medicines optimisation group. We saw that learning from safety incidents across the trust was shared with ward managers for discussion in team meetings.

The hospital did not always ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We saw that three patients' prescribed medicines exceeded the British National Formulary (BNF) maximum dose on some occasions. For example, we saw that staff exceeded the maximum dose of diazepam for one patient on Brecon ward on two occasions. Staff exceeded the maximum dose of lorazepam for one patient on Coral ward. There was no paperwork in place to authorise these additional dosages. Each patient had a Mental Health Act treatment form which stated that the maximum BNF dose should not be exceeded. These had not been reported as medicine errors.

Our findings

Staff reviewed the effects of most patient's medicines on their physical health according to NICE guidance. For example, staff monitored patients who were prescribed clozapine for signs of constipation, which can sometimes be a side effect of this medicine. Physical healthcare staff completed regular blood tests and electrocardiograms (ECGs) to monitor the effects of medication for patients who required this. However, staff did not always monitor patients' physical health after rapid tranquilisation was used.

Not all ward staff were up to date with their physical healthcare mandatory training. Only 30% of staff on learning disability and mental health wards and 40% of staff working in the women's service had completed this training course. We were concerned that the lack of training impacted on staff's ability to monitor physical healthcare.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff knew how to use the electronic incident reporting system and the types of incidents that needed to be reported. Managers had improved how they shared information about incidents with staff since our previous inspection. They regularly discussed incidents during daily handover meetings and regular multidisciplinary meetings. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. For example, staff informed patients if they made a medicine error and recorded that they had followed the duty of candour within incident reports.

Managers debriefed and supported staff after any serious incident. Staff told us that managers provided them with support after incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received information a monthly bulletin, which contained a summary of serious incidents that had occurred in forensic settings both internal and external to the trust. Staff did not always meet to discuss the feedback and look at improvements to patient care. Although staff discussed incidents in team meetings, these were irregular due to low staffing levels.

There was evidence that changes had been made as a result of feedback. For example, the hospital had implemented a work permit system to ensure that only authorised staff could access the CCTV room within the control room to review CCTV, following a data breach incident.

Managers shared learning with their staff about never events that happened elsewhere. For example, managers had shared the lessons learned from patient deaths that had occurred at other services within the trust.

Our findings

Is the service effective?

Requires Improvement 

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

Assessment of needs and planning of care

Staff had improved the assessment of the physical and mental health of patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed 50 patient care records and saw that staff completed a mental health assessment for each patient after their admission. Staff regularly reviewed and updated care plans when patients' needs changed.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We reviewed the physical health records of 31 patients and saw that each patient had their physical health assessed regularly. Staff appropriately monitored patients with long term health conditions, such as diabetes. The physical healthcare team completed a health assessment for all new patients.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.Care plans were personalised, holistic and recovery-orientated. Most of the care plans we reviewed showed evidence of patient involvement, individualised coping strategies and represented patient's needs. Most patients had a positive behaviour support plan in place which included primary, secondary and tertiary strategies for staff to use in order to prevent or respond to incidents. Each patient had a risk management care plan, which contained information about patients' risk to self, others and any identified risk of breaching security or attempting to escape.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They used recognised rating scales to assess and record severity and outcomes and participated in clinical audit, benchmarking and quality improvement initiatives. Staff supported patients to live healthier lives. Staff ensured that most patients had good access to physical healthcare. However, staff had not effectively supported two patients with mobility needs.

Staff provided a range of care and treatment suitable for the patients in the service. The hospital offered various interventions depending on patients' needs, such as dialectical behaviour therapy (DBT) and trauma informed care. A Trauma and Self Injury programme (TASI) was delivered in the women's service, this is a specialist programme which is designed to be used in women's forensic services. Psychologists on the learning disability wards used a specialist framework called SPELL to understand the needs of autistic patients.

Staff identified most patients' physical health needs and recorded them in their care plans. Staff now ensured that patients with known physical healthcare needs had a physical health care plan in place. These were detailed and covered essential information about how to manage patients' physical health needs. For example, we saw that staff had

included information about how to support a patient to use their wheelchair and the ward lift for one patient on Cotswold ward, in order to effectively meet their care needs. Physical health care plans included information about how to appropriately monitor and support patients long term health conditions, such as diabetes. Staff recorded information about patients' allergies.

Ward staff now had better access to patients' physical health information. Staff told us that they now had easy access to physical healthcare information and that the physical healthcare team updated records and called the ward teams to provide results following tests they completed for patients, such as blood tests.

However, during the inspection we found that ward staff had not supported two patients with their physical healthcare needs. A patient on Emerald ward needed to wear splints in their shoes to help with mobility but these had gone missing, replacements had been ordered. The care plan did not give information about how staff could support the patient to safely mobilise in the meantime and still included the use of splints as an intervention, despite these not being available. We were concerned that this could increase the risk of falls for this patient or have a negative long term impact on their mobility. Staff on Canterbury ward had not ensured that a patient who was at high risk of falls had a dedicated falls care plan in place. Although the care plan contained some information about their mobility needs, there was no information about how staff should support the patient to reduce the risk of falls. Care records showed that this patient had experienced several falls on the ward.

Staff made sure patients had access to physical health care, including specialists as required. Managers had improved patients' access to physical healthcare specialists since our last inspection. Staff referred patients to the physical healthcare service when this was needed. The physical healthcare services ran various clinics such as ear care, wound care, physiotherapy and a routine GP clinic. They also completed smear tests, bowel and breast checks, vaccinations, and blood tests. The physical health centre also delivered an urgent care service which included responding to medical emergencies on the wards. The urgent care service was available between 8am and 10pm, there were plans for this to operate as a 24 hour service in the future. Patients had input from specialist such as speech and language therapists and dieticians when required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff included information about patients' dietary needs within their care plans. For example, staff had clearly documented the dietary requirements of one patient on Coral ward and one patient on Canterbury ward who had been prescribed a soft diet. We saw that both of these patients had involvement from dieticians and speech and language therapists. One patient had been referred to the gastroenterology team at the local hospital for further support and assessment.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The physical health team delivered health promotion sessions on the wards and supported patients to learn about self-examination using prosthetic breasts and testes. We saw that a patient on Kempton ward had received advice about healthy lifestyles and had an exercise plan in place. Monthly health promotion sessions had been arranged on Jade ward, covering breast examination, hand hygiene and oral hygiene.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used rating scales such as the Health of the Nation Outcome Scale (HONOs), Model of Human Occupation Screening Tool (MOHOST) and the Dynamic Appraisal of Situational Aggression (DASA). These were completed on admission and reviewed regularly.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Quality matrons had started to complete audits of staff recording of physical observations and of the malnutrition universal screening tool (MUST) and

shared these results with ward managers. Ward managers completed regular audits of patient care plans and risk assessments. Other audits included the use of the Mental Health Act and Mental Capacity Act, pharmacy audits and infection prevention and control audits. Managers used results from audits to make improvements. For example, managers in the learning disability service had created a quality improvement plan to address the areas for improvement that had been identified in a recent audit of the application of the Mental Health Act and Mental Capacity Act.

Staff used technology to support patients. Staff recorded patient observations on electronic tablet devices and told us that these were readily available and easy to use.

Skilled staff to deliver care

The trust had not ensured that ward teams had access to the full range of specialists required to meet the needs of patients since our last inspection. They did not always support staff with appraisals and supervision. However, managers tried to ensure they had staff with the range of skills needed to provide high quality care and provided an induction programme for new staff.

The service did not have access to a full range of specialists to meet the needs of the patients on the ward. We found that not all patients had access to occupational therapists to support their treatment. There was no occupational therapists employed in the women's service as all of the occupational therapists had left. There were occupational therapy vacancies on various other wards. The women's service had technical instructors who supported patients to complete activities but they were often redeployed due to low staffing levels across the hospital. Occupational therapy assistants and technical instructors in the women's service received some support from an occupational therapist based on mental health wards.

Managers ensured staff had the right skills and qualifications to meet the needs of the patients in their care, including bank staff. All new staff members received an induction to the hospital. This included training on security procedures, personal safety, relational security, managing violence and aggression, restraint and key training. In addition to the generic hospital induction, managers gave each new member of staff an induction to their ward. New members of staff were assigned a mentor on their ward, however, two staff told us that their mentors often redeployed to other areas due to low staffing levels. Some staff told us that they were moved to wards they were unfamiliar with and asked to perform tasks that did not form part of their usual role. For example, technical instructors usually supported patients with activities but were regularly redeployed as health care assistants to wards. Two technical instructors told us that this had affected morale and staff became anxious as they did not know where they would be working on a daily basis.

Managers supported staff through regular, constructive appraisals of their work. Eighty four per cent of ward staff had received an appraisal between February and July 2022. Managers recognised poor performance, could identify the reasons and dealt with these.

Managers did not always support staff through regular, constructive clinical supervision of their work. Although some staff told us that they received regular clinical supervision, managers told us that formal supervision could not always take place due to low staffing levels. We reviewed clinical supervision data and found that the average supervision level for all wards was 59% between February and July 2022. Supervision was lowest on Cheltenham and Malvern wards, 42% of staff on these wards had received supervision during this period. Evans ward had the highest rate of clinical supervision at 93% for this period.

Managers did not always make sure staff attended regular team meetings or gave information from those they could not attend. Managers told us that they had not been able to have regular team meetings due to low staffing levels. We

reviewed team meeting minutes on some wards and found that meetings were irregular. For example, there had been no team meetings on Aintree ward since March 2022 and no team meetings on Adwick ward since May 2022. We saw that managers on some wards sent a regular email out to staff to inform them of important updates. We saw this on Aintree ward and in the women's service.

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

Managers made sure staff received any specialist training for their role. We saw that some ward staff had been approved to attend a training courses on learning disability and autism and Radically Open Dialectical Behaviour Therapy. This was a therapeutic technique had started to be delivered to patients on some wards. The psychology team had created a new training programme regarding equality, diversity and inclusion. This had been trialled and was soon to be extended to the wider staff team. However, there were not enough staff trained in British Sign Language to meet the needs of deaf patients.

Managers recruited, trained and supported volunteers to work with patients in the service. The hospital had a volunteering befriending service, who contacted patients who did not have any other visitors.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff had improved how they discussed patients at handover meetings and ward round meetings. We observed a ward round meeting on three wards and saw that these included consultants, nurses, psychologists and managers. We observed that patients were invited to attend their ward round review and were encouraged to contribute to this.

Each patient had a regular care programme approach (CPA) review meeting. Members of the multidisciplinary team such as psychologists, social workers and speech and language therapists each prepared reports of patients progress for CPA meetings.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handover meetings took place on each ward at least twice a day. We observed a handover meetings on Quantock, Cotswold and Grampian wards and saw that these were detailed and staff shared essential information about patient needs, risks and observation levels.

Ward teams had effective working relationships with other teams in the organisation. For example, staff on Grampian ward had provided advice and support to staff on Coral ward to help them to support a deaf patient. The ward manager for Grampian visited Coral ward to provide deaf awareness sessions to the multidisciplinary team. We observed that multidisciplinary teams on Quantock and Cotswold jointly reviewed risk for two patients following an incident.

Ward teams had effective working relationships with external teams and organisations. Ward teams invited care coordinators and other providers to review meetings to plan patient's discharge from the hospital.

Our findings

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

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

Not all staff received and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice. Eighty four per cent of all ward staff had completed Mental Health Act training. However, eight wards had a training compliance rate of below 80%. This was lowest on Eden and Newmarket wards. Only 60% of staff on Eden ward and 64% of staff on Newmarket ward were update to date with their Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff could get advice from the hospital's mental health act administrators. This team reminded ward teams when patients needed to have their Mental Health Act rights repeated to them.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. For example, it had a policy for the management of incoming and outgoing mail, this included guidance on withholding and monitoring mail. However, staff did not always follow this. We reviewed the mail and telephone monitoring arrangements for 11 patients and found that staff only reviewed this regularly for one patient. This was not in line with the trust policy, which outlined that the decision to monitor mail and telephone calls should be regularly reviewed and recorded during clinical team meetings.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Patients told us that they knew how to access support from an advocate if they needed this. Advocates completed monthly drop in visits to each ward and attended community meetings.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We saw evidence in patient care records that staff regularly reminded patients of their rights under the Mental Health Act.

Staff made did not always ensure that patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Patients were not always able to take their grounds leave due to low staffing levels. However, patients had access to leave for medical appointments and treatment.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. For example, managers had recently completed an audit of the Mental Health Act paperwork on learning disability and women's wards. A meeting was planned to consider how the audit programme could be extended to the other ward areas.

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

Good practice in applying the Mental Capacity Act

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

Our findings

Not all staff received, and were consistently up-to-date, with training in the Mental Capacity Act. We reviewed training data and found compliance with Mental Capacity Act training was below 80% for 14 out of 24 wards. Only 56% of staff on Hambleton ward had completed their Mental Capacity Act training. However, the staff we spoke with had a good understanding of the five principles.

There was a clear policy on Mental Capacity Act, which staff could describe and knew how to access. Staff could access this policy on the trust intranet page.

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

Staff assessed and record capacity to consent clearly each time a patient needed to make an important decision. Staff recorded patients' consent to medical treatment. We saw that staff had completed a mental capacity assessment for a patient regarding appropriate food choices for a patient on Coral ward. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. Managers had recently completed an audit of the Mental Capacity Act paperwork on learning disability and women's wards. A meeting was planned to consider how the audit programme could be extended to the other ward areas.

Is the service caring?

Requires Improvement 

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

Kindness, privacy, dignity, respect, compassion and support

Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. However, the ability of staff to ensure patients' care plans were followed was sometimes impacted by low staffing levels. Most treated patients with compassion and kindness and respected patients' dignity and privacy. However, we observed CCTV footage of an incident where a patient was physically pushed by a member of staff and witnessed that privacy and dignity was not maintained for another patient.

Most staff were respectful and when caring for patients. However, staff were not always responsive. Staff regularly confined patients to their bedrooms during the day, due to low staffing levels. This meant that staff could not always care for patients in a way that reflected their needs and preferences. Patients told us that staff were not always available to offer support and some staff told us that they did not always feel able to give patients help, emotional support and advice when they needed it, due to the low staffing levels.

The hospital did not have enough staff trained in British Sign Language to support the needs of deaf patients. This meant there were often times where staff could not effectively communicate with or offer an appropriate level of emotional support and reassurance to those deaf patients for whom British Sign Language was their first language.

Our findings

Patients said staff treated them well and behaved kindly. Overall, patients told us that staff were kind. We observed that staff were respectful in their interactions with patients on the wards we visited. However, we reviewed CCTV footage of one incident where a patient was physically pushed by a staff member on Coral ward.

Staff did not always maintain patients' privacy and dignity. We observed that a patient on Emerald ward was not afforded full privacy when they used a toilet that was located within a communal lounge. The toilet was in located in a cubicle with a viewing pane with a separate sink. The toilet area was separated from the lounge by an adjoining door, during a tour of the ward a staff member told us that they should stand in the toilet area to supervise the patient but close the adjoining door to ensure the patient had privacy. However, we later observed that a staff member did not close the adjoining door when they supervised a patient to use the toilet, as they were talking to a staff member in the lounge. This meant that staff and patients in the communal lounge could have heard the patient in the toilet.

Staff supported patients to understand and manage their own care treatment or condition. Staff involved patients in discussions about their care and treatment in ward round meetings and were able to discuss their medicines with consultants.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff understood and respected the individual needs of most patients. Most patient care plans included information about patients' personal, cultural, sexual and religious needs. Staff ensured that they shared the needs of patients with other staff members who were unfamiliar with these. For example, we observed staff on Aintree ward provided visitors to the wards with advice on how to adapt their communication style to suit a patient on the ward who could not tolerate eye contact. We saw that staff on Newmarket ward had involved a patient in developing a care plan that accurately and sensitively reflected their needs and preferences in relation to their gender identity. However, the patient told us sometimes there were not enough staff to enable some parts of their care plan to be followed.

We saw that staff had not followed the recommendation from a recent Independent Care (Education) and Treatment Review to work with the patient and their family to develop a care plan that met their cultural needs. However, the patients care plan stated that the patient did not have any cultural needs. The patient was of a black and minority ethnic background and told us that staff did not offer him meals that met their cultural needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. However, staff did not always raise concerns when they should have. We reviewed CCTV of an incident where a staff member physically pushed a patient on Coral ward. This was witnessed by a member of staff, who did not inform a manager of what had happened.

Staff now followed policy to keep patient information confidential. This had improved since our last inspection.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients told us that they had received information about the ward when they were admitted and staff had showed them around.

Our findings

Staff involved patients and gave them access to their care planning and risk assessments. Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff developed easy read care plans for patients who needed these. Learning disability wards used an easy read ward round template, to help patients to plan what they wanted to discuss during their ward round meeting. Staff on Grampian ward ensured that patients had access to an interpreter for ward rounds and review meetings.

Staff involved patients in decisions about the service, when appropriate. Patients from each ward attended a monthly patient involvement meeting. This was attended by senior managers. Patients were able to give feedback and contribute to discussions about service developments. The hospital involved patients in staff interviews. Patient representatives had been invited to sit on the interview panel for new staff members.

Patients could give feedback on the service. Staff supported patients to give their feedback in the annual patient survey. We reviewed themes from the latest patient survey, the most common issues that patients raised related to low staffing levels and a lack of activities. Patients could also give their feedback in community meetings on each ward but we saw that these meetings were did not occur regularly. Staff told us that community meetings sometimes could not be facilitated due to low staffing levels.

Staff supported patients to make advanced decisions on their care. Staff recorded evidence of advance decisions in patient care plans where this was relevant. For example, we saw that an advance decision about how medicine should be given during restraint had been documented for one patient on Coral ward.

Staff made sure patients could access advocacy services.

Involvement of families and carers

The hospital had systems in place to inform and involve families and carers but these were not always effective.

Staff tried to support, inform and involve families and carers. Social workers for each ward took the lead on maintaining contact with carers. However, we spoke with five carers and each of them told us that they communication from staff could be improved. We saw that carers had also raised the issue of communication in a recent carer's workshop and wanted more communication from other members of the clinical team.

The family and volunteer support service ran regular carer engagement events. Recent events had taken place virtually due to COVID-19 restrictions, but staff were planning their first face to face session.

Due to COVID-19 restrictions, some carers had been unable to complete face to face visits. The hospital had arranged for each ward to be able to facilitate video calls between patients and carers, called 'Purple Visits'. These had been well received by patients and carers.

Staff helped families to give feedback on the service. Staff collected feedback from carers after engagement events.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Requires Improvement 

Our findings

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

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

In July 2022, the average bed occupancy for all wards was 88%. Newmarket, Burne, Evans and Hambleton wards each had patients on leave at the time of our inspection. Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Patients in the women's service had a length of stay of three years and five months, this was higher than any other service. The length of stay was highest on Ruby ward, which had a length of stay of five years eight months. Three patients on this ward had been assessed and accepted by alternative placements and were waiting for a bed to become available.

Twenty five per cent of patients at the hospital had a length of stay of ten years or more. Two patients had a length of stay of 29 years.

The service had high out-of-area placements. The hospital provided regional mental health and personality disorder services. The hospital was the only one in England to commission high secure services for women and deaf patients, therefore patients were admitted to these wards from across the country.

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

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. For example, patients were moved to intensive care wards if their mental health significantly declined and if the multidisciplinary team felt they would benefit from a higher level of support.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Delayed discharges had decreased from 24 in September 2021 to 19 in August 2022. Staff actively worked with external agencies to find suitable placements for patients. We saw that five patients were waiting for approval from the Ministry of Justice to move to another placement, five patients were waiting to be assessed and five patients had been assessed and were waiting for a bed to become available at their identified placement. The hospital regularly reviewed patients who were waiting to be discharged. The hospital had plans to develop a patient outreach service, to support patients after they had been discharged to other services, to reduce re-admission, and to offer support to patients who were waiting for a bed to become available.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff had regular meetings with external teams to plan and monitor the progress of patients' discharge. Patients were involved in their discharge planning and some patients we spoke with told us about their discharge pathway.

Our findings

Staff supported patients when they were referred or transferred between services. For example, we saw that staff had created a transition plan for a patient on Topaz ward who was due to be discharged to a medium secure service, which included visits and virtual meetings with staff. Hospital staff liaised with external staff to arrange a 'virtual tour' for a patient on emerald ward who was due to be discharged to a medium secure service. We saw that some patients were on trial leave to other services during our inspection.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of most wards supported most patients' treatment, privacy and dignity. However, patients on Adwick ward did not have access to ensuite facilities. Patients could not make hot drinks and snacks at any time and relied on staff to give them access to these facilities. However, patients could keep their personal belongings safe and there were quiet areas for privacy.

Each patient had their own bedroom, which they could personalise. We saw that some patients had been able to personalise their bedrooms with photos and personal belongings. Patients had a secure locker on the ward place to store personal possessions. Patients were only allowed to have 120 personal items on the ward at a time. Any other belongings were stored in a secure storage facility located on the hospital site. Staff supported patients to visit the storage facility to store or collect items.

The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. The range of rooms on each ward varied but all wards had a communal lounge, dining room, and therapy rooms.

The service had quiet areas and a room where patients could meet with visitors in private. Visiting rooms were located in the main hospital building. Each ward had quiet rooms where patients could have video calls with family and professionals.

Patients could not make phone calls in private. We observed that patient telephones where located on the ward corridor, patients told us that they felt they had no privacy when they made a phone call because of this.

All wards had access to a designated outdoor space. However, staff could not always support patients in long term segregation to access this due to low staffing levels.

Not all patients could make their own hot drinks. Most wards had hot and cold water dispensers that patients could access in communal areas. Patients could store snacks in communal fridges and individual lockers. However, patients could not access these areas without staff supervision and did not have access when they were confined to their bedrooms. This meant they often relied on staff to access hot drinks and snacks. One patient on Kempton ward told us that there were not always enough staff to unlock the dining room to enable patients to get drinks when they wanted to.

The service offered a variety of food, but this was not always of good quality. Some patients we spoke with told us that meals could be improved. We saw that patients had raised the issue of food being cold when it reached the ward in some patient involvement meetings. The hospital had a Food and Shop group, which met regularly to discuss issues with food. This was attended by senior managers, dieticians, patients and a manager from the catering team.

Patients' engagement with the wider community

Staff did not always support patients with activities outside of the ward, such as work and education. However, they did help patients to maintain family relationships.

Our findings

Staff did not always make sure patients had access to opportunities for education and work, and supported patients. Each care pathway had access to a day unit. The day units were well equipped and included recreational and educational resources. Patients had access to activities such as arts and crafts, horticulture and woodwork. However, patients were not always able to access these centres due to low staffing levels.

Staff helped patients to stay in contact with families and carers by organising face to face visits, video calls and phone calls.

Meeting the needs of all people who use the service

The service met the needs of most patients but there were not enough staff trained in British Sign Language (BSL) to meet the needs of deaf patients. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people. Patients had access to easy read resources to help them to understand their care and treatment. Patients who were wheelchair users were cared for on wards that were accessible.

The service did not have enough staff trained in BSL to support the needs of deaf patients on Grampian ward. The number of BSL trained staff had decreased since our last inspection. Only eight out of 25 nursing staff were trained to BSL level two. This level of training allows staff to engage in everyday conversation with deaf patients. Two out of 25 were training to BSL Level three. Three out of the 10 multidisciplinary staff members on Grampian ward were trained to level 6 and seven were trained to either level one or two.

Grampian ward did not have any guidance in place regarding the minimum number of staff who should be trained in BSL and the minimum level of training. We reviewed rotas for Grampian ward between 8 August and 2 September 2022 and found there were six day shifts in this period that did not have a staff member trained to level 2 BSL. We saw that 35 out of 56 night shifts in this period had no staff member trained to BSL level two.

Deaf patients did not have enough access to BSL interpreters. These were external, non-clinical staff members who were specifically employed to support the communication needs of deaf patients. Interpreters visited Grampian ward Monday to Saturday between 8:30am and 4:30pm. For five out of six days, only one interpreter was available to support seven patients who were on the ward at the time of our visit. We saw that additional funding had been agreed for some additional hours to be provided on a Sunday but we were concerned that there were not enough interpreters to meet the needs of patients. Patients told us that they were frustrated about the lack of interpreters on the ward, as the interpreter often had to attend meetings and medical appointments for specific patients, which meant the patients on the ward were left without interpreter support at times.

There was also one deaf patient on Coral ward, who had limited access to BSL trained staff and interpreters. Whilst the patient had access to an interpreter five days per week, until 4pm no other staff who worked on the ward during the day was trained in BSL. A staff member from Grampian ward had recently started to work night shifts on Coral ward and was trained to BSL level three. There was also one deaf support worker who worked on Coral ward. However, this meant there were regularly times where the patient did not have support in place to communicate their needs and therefore could not always communicate their needs effectively to staff. Staff on Coral ward had liaised with Grampian ward to try and increase the patient's access to deaf support resources and an agreement was in place for Grampian BSL trained staff to support Coral ward staff. However, we were concerned about the ability for this to be facilitated regularly when Grampian ward itself did not have enough BSL trained staff and limited interpreter cover.

Our findings

The deaf patient on Coral ward had limited opportunity to mix with their deaf peers on Grampian ward. The patient told us that they wanted to attend the deaf social club, which takes place every month on Grampian ward, but they were not allowed to attend this, the patient could only access this via a video call. The patient told us that this was this frustrating.

Managers made sure staff and patients could get help from other interpreters when needed. The trust had its own interpreter service for a range of languages, staff told us they could access this when they needed to.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Patients told us that they could access this information when they needed to. The service had information leaflets available in languages spoken by the patients and local community. Staff could order information leaflets in different languages if patients needed them. One patient on Grampian ward could not read or speak English. We saw that they had a channel on their television which used BSL to explain what they should do if the fire alarm sounded. Patients on Grampian ward also had access to deaf community television channels.

Patients had access to spiritual, religious and cultural support. The chaplaincy service offered a range of religious and spiritual support. For example, we saw that Muslim patients had access to prayer mats. Religious leaders for a variety of faiths attended wards to lead on religion ceremonies and prayer. The hospital also had a church on site and various multifaith rooms for patients to access. Staff ensured that religious and cultural information was included within patients' care plans. The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. We spoke with patients who told us that they had raised complaints to the ward manager. Staff supported patients to make formal complaints and to give their feedback about their experience. For example, staff supported patients to leave their comments on 'Care Opinion' which is a website for people to share their experiences of health and social care in England.

The service clearly displayed information about how to raise a concern in patient areas. Staff supported patients to raise complaints.

Staff understood the policy on complaints and knew how to handle them. We saw that staff had arranged for an advocate to meet weekly with one patient who made repeated complaints about their care. Staff had developed a care plan regarding complaints to ensure that this patient received the correct support.

Managers investigated complaints and identified themes. Managers kept a log of complaints on their wards. Complaints across the hospital were overseen by the trust's complaints department. Complaints were investigated by senior members of staff. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Patients received feedback in a formal letter which contained information about what they should do if they were not satisfied with the outcome of the complaint.

Our findings

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff discussed complaints during team meetings but these did not happen regularly on all wards due to low staffing levels. However, staff could view information about lessons learnt from complaints on the trust intranet. Each ward had a lessons learnt folder which contained information about the outcomes of complaints.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. However, leaders had not yet fully addressed cultural concerns since our last inspection.

The trust leadership structure had changed significantly since our previous inspection. As part of this restructure, new posts had been created, such as new medical leads, quality matrons and security liaison nurses. The hospital had also developed its own improvement board, which met regularly to discuss key issues and challenges across the hospital and tracked progress that had been made in addressing its improvement plan. The board consisted of senior leaders at the hospital. It had been developed to provide assurance to the wider trust board and was attended by the trust's chief executive.

The hospital had appointed five medical leads, one for each care pathway at Rampton. The role of the medical leads supported links between wards and the senior leadership team. Medical leads met with each other weekly, attended regular meetings on the wards in the wider forensic care pathway and gave regular updates to the medical staff committee. However, some of the medical leads told us that they communication with the senior leadership needed to be improved. For example, some medical leads felt that leaders had not consulted with them about recent nursing restructures and had felt that their opinion had not been valued by the leadership team.

The hospital had developed a new quality matron role. Nine quality matrons had been appointed, with the aim of providing support to every ward. Some staff were unsure about what the role of the quality matron was and felt that the visibility of quality matrons on some wards could be improved. The role of quality matrons was varied. For example, they completed audits of care plans, attended ward round and patient involvement meetings. Some of the quality matrons led on specific areas, such as infection prevention and control and culture.

Staff had opportunities to progress, we saw that some experienced staff had been successful in obtaining the new quality matron posts. However, some staff were concerned that this reduced the number of experienced nursing staff available on the wards.

Staff told us that ward managers were visible, approachable and supportive. We saw that ward managers stepped into ward numbers to help when wards where low staffed. Most staff felt that senior leaders were now more visible and approachable and they often saw service managers on the wards.

Our findings

Vision and strategy

Not all staff behaved in line with the provider's values and some staff did not feel involved in discussions about organisational change. However, staff understood the provider's vision how it applied to the work of their team.

Staff we spoke with were aware of the trust's values of trust, honesty, respect, compassion and teamwork. Information about the trust's vision and values were displayed throughout the hospital. However, we found examples where staff had not behaved in line with these values. A staff member appeared to witness another member of staff push a patient but had not reported this incident to senior managers. Some staff raised concerns that the discussions staff had in front of patients were not always appropriate, such as discussing life outside of work. Staff reported that some patients were very sensitive to the language used by staff and that this may have led to incidents, particularly in the women's service and the personality disorder service.

We were not sure that all staff felt that they had been able to contribute to discussions about the recent staff restructure, some staff told us that they had not been adequately consulted about this.

Culture

We were concerned that the work that leaders had undertaken to improve the culture of the hospital since our last inspection had not been fully embedded, as we identified some indicators of a closed culture during our inspection.

Most staff told us that they were now able to speak up about their concerns but one member of staff had not spoken up after they appeared to witness another staff member pushed a patient. Two out of 102 staff we spoke with told us they felt unable to speak up as they felt their managers would not listen to them, or they would be moved to another ward.

Three staff raised concerns about the nature of discussions that staff had in front of patients and about the language used by staff. During the inspection we spoke with one member of staff on Kempton ward who used inappropriate language to describe the use of seclusion and restraint.

Two staff told us that some staff were not always sensitive to patients' cultural backgrounds. Two other staff told us that they had experienced patients using racist language towards them and felt that leaders in the hospital had not done enough to address this.

The quality matrons had completed a cultural review of each of the care pathways at Rampton. These reviews aimed to identify and address any risks that could contribute to a closed ward culture. However, no recommendations had been made within the cultural review of the women's, mental health and personality disorder services and no dates had been arranged to follow up on those services where recommendations were made. We were concerned that these reviews may not effectively identify and address cultural issues within the hospital.

Since the previous inspection, senior leaders had appointed 15 equality, diversity and inclusion ambassadors for each ward and for the social work, psychology and physical healthcare divisions. An equality diversity and inclusion strategy for the forensic division was launched in May 2022, this set out the equality diversity and inclusion objectives to be achieved over the next five years. The hospital had its own quality improvement plan which was aligned to the strategy and kept track of actions to be completed over the next 12 months. We saw that several actions had been completed and other actions were in progress. A monthly equality, diversity and inclusion newsletter has recently been developed and was available to staff within the hospital and the wider forensic division.

Our findings

Although the hospital had systems in place to inform and involve families and carers, these were not always effective. Five carers we spoke with told us that communication from staff could be improved. However, they were able to give their feedback about the service and raise concerns. Managers made sure that they provided patients and carers with a response to complaints. Senior managers attended monthly patient involvement meetings.

Governance

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

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared. However, there was limited opportunity for staff to discuss and reflect on information, as ward team meetings, reflective practice and group supervision sessions were infrequent and had been negatively impacted by low staffing levels.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff shared key learning from incidents within the hospital and wider trust with staff.

We found that some governance processes and clinical audits did not work effectively to improve outcomes for patients. For example, an audit of seclusion paperwork had not addressed that patients who used seclusion did not have a specific seclusion care plan in place, this was not in line with the trust's seclusion policy.

We were not assured that the systems and processes in place to monitor the use of rapid tranquilisation were effective. Although there was an annual audit of this, we found that staff did not always monitor patients' physical health after rapid tranquilisation was used. This had been raised as an issue at the last inspection.

We did not see evidence the multidisciplinary team regularly reviewed the mail and telephone monitoring arrangements of the patients who were subjected to this, in accordance with the Mental Health Act code of practice.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. Staff told us that access to the physical healthcare service had improved and that staff in this service were easily accessible and visible.

The trust had a reducing violence and restrictive intervention strategy, this set out the trust's aims to reduce restrictive interventions. The trust also had a Restrictive Interventions Strategic Oversight group, this was attended by Rampton's designated lead for restrictive practices.

Management of risk, issues and performance

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

The hospital now has a risk committee, which reports directly to the board

Staff maintained and had access to the risk register at Directorate level. Rampton Hospital had its own risk register, the hospital escalated the most serious risks to the trust's risk register.

Our findings

Although low staffing levels featured on the risk register as a medium risk, we did not identify any significant action that had been taken since the last inspection to improve this. We were concerned that this did not reflect the full impact that low staffing levels had across the hospital site. However, senior managers had a good oversight of the staffing issues and had a staffing contingency plan in place which enabled staff to identify and respond to the highest risk areas of the hospital. Staff concerns matched those on the risk register.

The service had plans for emergencies. The hospital had developed and implemented contingency plans related to low staffing levels and COVID-19. These clearly identified how non- essential services would be paused to enable staff to manage risk at times of low staffing and in the event of a COVID-19 outbreak.

The hospital had two designated safeguarding leads who took the lead responsibility for the protection of patients. Social workers were visible on the wards and provided advice and support to nursing staff and patients. However, we were concerned that patient on patient assaults were not always recorded as safeguarding events. This raised concerns about the oversight of safeguarding at the hospital.

Information management

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

Managers collected and reviewed data about performance, staffing, patient care and ward security. Each ward had its own quality improvement plan.

Staff had access to the equipment and information technology they needed to do their work. Ward staff now recorded patient observations using an electronic tablet. Most staff told us that this worked well and there were enough tablets on each of the wards we visited. Observation records from the tablet automatically transferred to the computer system after 24 hours, which enabled managers to easily complete audits of this data. Staff knew how to access the incident reporting system.

We were not assured that staff accurately and consistently reported safeguarding incidents. Due to the under-reporting of patient on patient assaults as safeguarding incidents, we were concerned that staff had not always report safeguarding concerns to the local authority safeguarding team as required.

Engagement

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

Managers had good relationships with external professionals, including NHS England and local commissioning teams. The hospital provided a weekly update to NHS England to report on the impact of COVID-19. The hospital met regularly with the other high secure hospitals and participated in a peer review programme.

Staff and patients had access to up to date information about the work of the hospital and the services they used. Managers shared feedback and information about lessons learned through emails, the staff intranet and television screens throughout the hospital. Leaders shared service development updates with patients during patient involvement meetings. Staff and patients had co-produced a quality improvement plan which focused on patient experience. The hospital ran regular carer engagement events. Although these had been moved to online sessions, the hospital was planning its first face to face carer event since COVID-19.

However, staff did not have the time or space to engage with and reflect on with these updates. We saw that team meetings and staff away-days had been cancelled due to low staffing levels. We noted that most wards had irregular community meetings, so this reduced the opportunity for staff and patients to engage with each other.

Learning, continuous improvement and innovation

Staff had opportunities to participate in research. We saw that there were a number of active research and quality improvement projects that staff were participating in. For example, there were ongoing projects to reduce the number of medicine errors on Topaz ward and to increase patient's access to meaningful activities in seclusion on Aintree ward. The list of quality improvement projects was displayed on the trust's intranet page. Staff told us that they felt they had opportunities to progress.

We saw examples of innovative practice in the physical healthcare centre. Staff used a device called 'the listening ear' to help patients to relax and to reduce anxieties around their medical treatment. The listening ear was a device which detected when the sound levels increased, and changed colour to either green, amber or red to indicate the sound level in the clinic. This allowed staff to monitor and adjust the sound level in the physical healthcare suite, to meet the sensory needs of patients.

The hospital celebrated the success of its staff and patients. Aintree ward had recently won a Team of the Year award at the trust's annual awards ceremony, staff on the ward were proud of this achievement. The hospital had also won recent awards in the National service user awards, including one for the events that staff and patients on Grampian ward had delivered during Deaf Awareness Week.

Our findings

Outstanding practice

We found the following outstanding practice:

- The physical healthcare service was now more visible in the hospital and had improved its communication with staff on the wards. The physical healthcare service used innovative ways to improve the experiences for patients with sensory needs, by implementing a 'listening ear', a device which allowed staff to monitor and adjust the noise levels within the psychical healthcare suite, to help patients to relax and to reduce anxieties around their medical treatment. Staff in the physical healthcare service had involved patients in their review of the cervical screening programme and had changed the layout of the clinic room based on their feedback. Staff also introduced the use of music and aromatherapy to improve the experiences of patients during cervical screenings.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Following this inspection, we served a warning notice. This informed the trust that they needed to make significant improvement. We also served the following requirement notices:

High Secure Hospitals

- The trust must ensure it maintains safe staffing levels across the hospital to facilitate access to activities, leave and fresh air (Regulation 18(1)).
- The trust must ensure it employs enough staff trained in British Sign Language to meet the needs of deaf patients within the hospital (Regulation 18(2)).
- The trust must ensure that staff receive regular clinical and managerial supervision, in line with the trust's policy (Regulation 18(2)).
- The trust must ensure that all staff receive and are up to date with mandatory training, including Hospital Life Support (Regulation 18(2)).
- The trust must ensure that staff record patient observations in line with the trust's policy (Regulation 12(1)).
- The trust must ensure that staff complete appropriate physical health monitoring of patients post-rapid tranquilisation (Regulation 12(1)).
- The trust must ensure that staff effectively manage patient's access to risk items (Regulation 12(1)).
- The trust must ensure that staff develop and implement seclusion care plans for patients who require these, in line with the trust's policy (Regulation 12(1)).
- The trust must ensure that staff effectively identify and respond to the deteriorating physical health of patients and seek medical attention promptly when this is required (Regulation 12(1)).

Our findings

- The trust must ensure that staff protect patients from abuse (Regulation 12(1)).
- The trust must ensure that effective systems and processes are in place to correctly authorise medicines in line with the Mental Health Act (Regulation 11(1)).
- The trust must ensure that effective systems and processes are in place to review mail and telephone monitoring arrangements, in line with the Mental Health Act (Regulation 11(1)).
- The trust must ensure that the blind spots identified in seclusion bathrooms on Coral and Grampian wards are mitigated to ensure that staff are able to effectively observe patients in these areas (Regulation 15(1)).
- The trust must ensure that all deaf patients have sufficient access to staff and interpreters who are trained to use British Sign Language and that deaf patients who are not placed on the national deaf service ward have opportunities to socialise with their deaf peers within the national deaf service (Regulation 9(1)).
- The trust must ensure that seclusion is used appropriately and proportionately (Regulation 13(1) & 13(4)).

Action the trust SHOULD take to improve:

High Secure Hospitals

- The trust should ensure that staff respect patients' dignity and privacy when they are observing patients in bathrooms, particularly bathrooms that are located within or close to communal areas (Regulation 10(1)).
- The trust should review the impact of discriminatory language towards staff from patients and how it can support staff (Regulation 17(1)).

Our inspection team

How we carried out the inspection

During this inspection we:

- Reviewed 103 prescription charts
- Reviewed 50 patient care records and 31 physical healthcare records
- Toured 14 wards, including 13 clinic rooms and 11 seclusion suites
- Visited two patient resource centres located within the hospital grounds.
- Spoke with 65 patients and six carers
- Spoke with a total of 102 members of staff, including senior hospital leaders and ward staff including consultants, nurses, healthcare assistants, psychologists and occupational therapists.
- Observed five multidisciplinary team meetings and three handover meetings
- Reviewed closed circuit television (CCTV) footage of four incidents
- Reviewed the seclusion care records for six patients
- Reviewed the care records for three patients who were cared for in long term segregation
- Reviewed the telephone and mail monitoring arrangements for 11 patients who were subjected to this.
- We also completed an offsite review of data we had requested during the course of our onsite inspection activity.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 11 HSCA (RA) Regulations 2014 Need for consent