Oldercare (Haslemere) Limited

St Magnus Hospital & Rosemary Park Nursing Home

Quality Report

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Date of inspection visit: 4-6 August 2015
Date of publication: 13/01/2016

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

Ratings

Overall rating for this hospital

Forensic/inpatient/secure wards	Good
Long stay/rehabilitation mental health wards for working age adults	Good

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because:

- Staff kept the wards very clean and well maintained and patients told us that they felt safe. Staff provided the ward environments to a high standard.
- There were enough, suitably qualified and trained staff to provide care to a good standard.
- Patients' risk assessments and plans were person centred.
- The service had clear mechanisms in place to report incidents and we saw that the service learnt from when things had gone wrong.

Are services effective?

Good

We rated effective as **good** because:

- The assessment of patients' needs and the planning of their care was thorough, individualised and had a focus on recovery. Physical healthcare assessments and associated plans of care were thorough and consistently delivered to a high standard.
- There was evidence of best practice and that all staff had a good understanding of the Mental Health Act 1983 (MHA), the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and the associated Codes of Practice.
- Throughout all of the wards, the multidisciplinary teams were consistently and proactively involved in patient care. Everyone's contribution was considered of equal value.
- The training and professional development opportunities offered to all staff and taken up was exemplary as all staff without exception commented on this.

Are services caring?

Good

We rated caring as **good** because:

- We consistently saw respectful, patient, responsive and kind interactions between staff and patients.
- All relatives and carers we spoke to, with one exception, commented on how caring and compassionate the staff were towards them and the patients.
- There were innovative practices used consistently across the service to engage and involve patients in the care and treatment they receive.
- There was a confident and thorough understanding of relational security among all of the staff.

Summary of findings

Are services responsive?

Good

We rated responsive as **good** because:

- Bed management processes were in place and effective.
- There were strong relationships with many commissioners.
- The service model optimised patients' recovery, comfort and dignity.
- There was a varied, strong and recovery orientated programme of therapeutic activities.
- The service was particularly responsive to listening to concerns or ideas made by patients and their relatives to improve services. Staff took ideas on board and implemented them wherever possible.
- The newly built and refurbished wards were of an excellent design and standard. We looked at the wildlife garden and saw the provider had gone above and beyond expectations in the interest of their patients and staff in providing such a remarkable and extraordinary beautiful environment. All patients could enjoy the outside facilities.

Are services well-led?

Good

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

- Staff told us they had good morale and they felt well supported and engaged with a highly visible and strong leadership team, which included both clinicians and managers.
- Staff at every level felt very much a part of the service and were able to discuss the philosophy of the hospital confidently.
- Managers had put controls in place to ensure good governance structures although these were not always formally set out or recorded for example in performance dashboards or a risk register .

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Forensic inpatient/ secure wards	Good	
Long stay/ rehabilitation mental health wards for working-age adults	Good	

St Magnus Hospital & Rosemary Park Nursing Home

Detailed findings

Services we looked at
Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults;

Detailed findings

Contents

Background to St Magnus Hospital & Rosemary Park Nursing Home

St Magnus Hospital has three locked recovery wards and three low secure wards for men only. The hospital specialises in the care and treatment of older adults and has a capacity for 42 patients in locked recovery and 34 patients in low secure wards. Cowdray, Petworth and Park House wards are locked recovery wards with eight, 16 and 18 beds respectively. Sycamore, Willow and Oak wards are low secure wards and have nine, nine and 16 beds respectively.

We have inspected the services provided at St Magnus Hospital three times between 2011 and 2013. At the time of the last inspection, St Magnus Hospital was fully compliant in meeting the essential standards inspected.

We have reviewed five of the wards at St Magnus Hospital between November 2014 and May 2015 through our Mental Health Act monitoring visits.

A registered manager and accountable officer were appointed at St Magnus hospital.

Our inspection team

Team leader: Jackie Drury

The team consisted of two inspectors, two experts by experience, a consultant psychiatrist and a Mental Health Act reviewer. (An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example, as a carer.)

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all three of the wards, looked at the quality of the ward environment, and saw how staff were caring for patients
- spoke with 19 patients who were using the service
- held a focus group for patients on one ward
- attended eight patient therapeutic activity groups

Detailed findings

- spoke with the managers for each of the wards
- spoke with 44 staff members, including doctors, nurses, support workers, senior support workers, occupational therapists, activity co-ordinators, social workers, ancillary staff and heads of department
- received feedback from five relatives
- spoke with three external commissioners
- spoke with a visiting general practitioner
- interviewed the safeguarding lead
- interviewed representatives from the education department
- interviewed the senior management team with responsibility for these services, including the hospital director and medical director
- held a focus group for four consultant psychiatrists
- held separate focus groups for activity co-ordinators and occupational therapists, social workers and heads of department
- attended and observed six multidisciplinary clinical meetings
- collected feedback from 14 patients using comment cards
- looked at 26 treatment records of patients, including medication records
- looked at six staff records
- looked at policies, procedures and other documents about the service.

Forensic inpatient/secure wards

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

Information about the service

St Magnus Hospital has three low secure wards for men only. The hospital specialises in the care and treatment of older adults and has a capacity for 34 patients. Sycamore, Willow and Oak wards are low secure wards and have nine, nine and 16 beds respectively.

- Oak ward provided a service for 16 patients with significant cognitive impairment, challenging behaviour and serious physical health problems.
- Sycamore ward offered nine patients initial assessment and an intensive care/high-dependency environment.
- Willow ward offered a service to nine patients with functional mental ill-health and personality disorder but with little or no cognitive impairment.

We have inspected the services provided at St Magnus Hospital three times between 2011 and 2013. At the time of the last inspection, St Magnus Hospital was fully compliant in meeting the essential standards inspected.

We have reviewed five of the wards at St Magnus Hospital between November 2014 and May 2015 through our Mental Health Act monitoring visits.

A registered manager and accountable officer were appointed at St Magnus Hospital.

Summary of findings

We rated St Magnus Hospital as **good** because:

Staff kept wards safe and clean and patients said they felt safe. There were enough suitably qualified and trained staff to provide care to a good standard. Staff kept person-centred patient risk assessments and formulations, which are plans to reduce risk. The service had clear ways to report any incidents which occurred and staff learnt lessons when things went wrong.

Nursing and medical staff assessed patients' needs effectively, planned their care thoroughly and individually, and focused on recovery. Physical health care assessments and associated plans of care were thorough and consistently delivered to a high standard. There was evidence of best practice and all staff understood the Mental Health Act 1983 (MHA), the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and the associated Codes of Practice. Throughout all of the wards, multidisciplinary teams consistently and proactively supported a high standard of patient care. The training and professional development opportunities offered and taken up by all staff was exemplary as all staff told us their training needs were appropriately accommodated.

We consistently saw caring, respectful, patient, responsive and kind interactions between staff and patients. All relatives and carers we spoke to, with one exception, said how caring and compassionate staff were towards them and the patients. The staff used

Forensic inpatient/secure wards

innovative practices consistently, to engage and involve patients in their care and treatment. Staff we spoke with were confident and understood how the relationship they had with patients affected a safe environment.

Staff managed the use of beds to meet people's needs and had strong relationships with many commissioners. Staff provided the service in a way that optimised patients' recovery, comfort and dignity. There was a varied, strong and recovery-orientated programme of therapeutic activities. The service responded to patients' and relatives' concerns or ideas to improve services. Staff listened to ideas and put them in place. The newly built and refurbished wards were provided to an excellent design and standard. In the wildlife garden the provider had gone beyond expectations to benefit patients and staff, by providing a remarkable and extraordinary environment. All patients could enjoy the outside facilities.

Staff told us that they had good morale and felt well supported and engaged with a highly visible and strong leadership team, which included both clinicians and managers. Staff at every level felt a part of the service and could discuss the hospital's philosophy confidently. Managers maintained strong controls to know that all was well but did not always formally set these out or record them, such as in performance dashboards or a risk register.

Are forensic inpatient/secure wards safe?

Good

Safe and clean environment

- Staff provided physical and procedural security consistently and to a good standard. Staff used policies and procedures to ensure the safety of patients, visitors and staff. There were a range of effective procedures across the service that enabled staff to establish and maintain clear boundaries across the site.
- There was a single main entrance to enter and exit the hospital with a comfortable reception area, furnished to a high standard and well equipped with soft furnishings. The entrance environment for patients, visitors and staff was welcoming, with comfortable furniture, lockers for storing personal belongings, cold water to drink, bathroom facilities, and a variety of relevant leaflets and information. Reception staff were professional and managed the area efficiently.
- Access into the three low secure wards was via a staffed reception and through an 'airlock' operated by reception. Staff signed into reception using automated fingerprint recognition.
- All areas of the hospital were within the secure perimeter fence and patients and staff had easy access into the wildlife garden.
- The layouts of the wards enabled staff to observe the majority of the ward areas. Where observation was restricted, we saw that staff put risk mitigation plans in place. Closed-circuit TV (CCTV) was available in all communal areas of all of the wards. Viewing panels in bedroom doors were not available on all of the wards. This meant staff had to open bedroom doors for day and night observation checks, with the possibility of disturbing the sleep of patients. All staff wore a wrist fob, which enabled access to all areas. Where it was possible, patients had a fob to their bedroom to enable access at times of their choosing.
- All wards had ligature risk assessments. Staff had taken specific action to mitigate the risks identified.
- All wards were gender specific and male only.

Forensic inpatient/secure wards

- Emergency equipment was stored in all wards in the nursing offices. A well-equipped clinical room was available. An automated external defibrillator and anaphylaxis pack were in place. Staff checked emergency equipment weekly to ensure it was fit for purpose and would be effective in an emergency. Staff were trained and able to respond to any physical health emergencies.
- None of the wards had a seclusion room.
- Two of the three low secure wards (Sycamore and Willow) opened in June 2015 having recently been built and commissioned and the third ward (Oak) was due to undergo a refurbishment within two months. Managers and staff had designed the two new wards to a high standard and the furnishings were in good order throughout all the wards. All en suite bedrooms were of a generous size.
- Staff maintained and cleaned all the wards to a good standard throughout. The provider had provided good quality furniture, fixtures and fittings. Staff conducted regular audits of infection control and prevention and staff hand hygiene to ensure protection for patients, visitors and staff against the risks of infection. Staff said that when they reported a fault or issue, the maintenance team responded promptly and effectively. Cleaning schedules were available in all areas.
- The staff carried out a range of environmental and health and safety audits. These included risk assessments and checks on standards of cleanliness.
- Alarms were available in each room on the wards and all staff carried alarms. Staff said they responded quickly to any alarms sounded.
- All wards took part in regular health and safety meetings and we looked at the minutes of these meetings.

Safe staffing and key staffing indicators

- Across St Magnus Hospital and Rosemary Park Nursing Home the establishment for substantive staff was 144 whole time equivalents. There was a projected 15% vacancy rate for St Magnus Hospital at the time of the inspection based on the staffing requirements for the new wards then being opened and enhanced staffing calculations for existing wards. There was a review of safe staffing levels and an increase in staff in May 2015 in order to ensure safe staffing of the newly reconfigured low secure and locked recovery wards. Staff were actively recruiting to fill these vacancies. Temporary staff filled 277 shifts in the period 1/03/2015 to 31/05/2015 in St Magnus Hospital, many to meet additional staffing requirements arising from increased patient needs such as one to one nursing and hospital appointment escorts, and no shifts were left uncovered. The annual sickness rate was low at 1.2% and the staff turnover rate was 10%.
- All the staff we spoke to said there were sufficient staff to deliver care to a good standard. Administrative staff were in place, to provide effective governance processes and support to clinical staff. This support enabled clinical staff to have time released to be able to prioritise the care and treatment of their patients.
- All the patients we asked said that they felt safe at St Magnus Hospital.
- We looked at six staff recruitment files and found them completed appropriately and to a good standard. Staff had carried out all the appropriate checks that should have been undertaken before new staff had started work. These included thorough identity checks, references, education certificate checks, completion of health questionnaires and satisfactory disclosure and barring service clearance (DBS).
- Ward managers and doctors told us that senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required. They gave an example where clinicians could enhance staff observation levels for patients when they were first admitted to the hospital to ensure safe and thorough risk assessing. On one ward, a recently admitted patient was on enhanced observation levels.
- The staff told us it was usually possible to escort patients on leave. Staff said they kept cancellation of escorted leave to an absolute minimum. They said if they did have to cancel leave, they routinely recorded this and escalated to senior managers.
- Patients received a one-to-one contact with a member of staff every day. We saw this recorded in the care records.
- Staff had trained in the use of physical interventions and staff on each shift were qualified registered general and mental health nurses. Many patients were frail and had physical health needs. There were sufficiently qualified staff available if required to assist.

Forensic inpatient/secure wards

- The wards had access to a wider multidisciplinary team, which included occupational therapists, psychologists, music therapists, art therapists, activity co-ordinators, a dementia nurse specialist, social workers, speech and language therapists and physiotherapists. The provider accessed specialist services when required, which included a tissue viability nurse, a diabetic nurse, chiropody, an optician and a dentist. Managers were available during night shifts. This showed us that the provider ensured a senior presence across a 24-hour period.
- Medical staff told us that there were adequate doctors available over a 24-hour period, seven days each week who were available to respond quickly on the wards in an emergency.
- In April 2015 staff had completed 91% of mandatory training.

Assessing and managing risk to patients and staff

- It was the provider's intention to manage behaviour without the use of seclusion. However the provider reported ten incidents of seclusion, using the latest Mental health Act Code of Practice definition of seclusion which took place in the past six months for very short periods of time and no incidents of long-term segregation. The highest number of seven episodes of seclusion was on Willow ward. There were ten incidents of physical restraint. One of these was in the prone position and resulted in rapid tranquilisation. There was however no seclusion room facility at St Magnus Hospital and staff said that on those occasions seclusion was required, the ward quiet rooms, sensory rooms and bedrooms were used. Staff told us that periods of seclusion lasted for minutes only as patients were easily distracted and calmed quickly. Staff told us that patients had significant levels of frailty and cognitive impairment and that they became less distressed if the short period of seclusion happened in their bedrooms. The provider had assessed that, given the added vulnerability of the patients at St Magnus, the use of a seclusion room would not be appropriate. At the time of our inspection, the provider was reviewing policies and protocols to reflect a range of restraint and seclusion practices. Department of Health guidance recommends the availability of a seclusion room in low secure services.
- Staff practiced relational security to a good standard and they actively promoted de-escalation techniques to avoid restraints where possible. The policy document related to restraint techniques was 'the use and care of responsibility techniques', and all staff had been trained. Relational security is when staff use their knowledge and understanding of their patients to maintain a calm environment.
- We looked at 26 electronic care records across all the wards, including many for those patients detained under the Mental Health Act. The wards used an electronic care record system (CareNotes), which included the risk profile documentation. Staff carried out a comprehensive risk assessment for patients on their admission. Patients, where they had wanted to and had consented to, had been actively involved in the risk assessment process.
- Patients' risk plans were good and staff reviewed them regularly in multidisciplinary meetings. Staff used the care programme approach (CPA) to assist risk management processes. We saw evidence that staff used a structured decision support guide, called the historical clinical risk management -20 (HCR-20), to assess risk factors for violent behaviour. Staff rated patients' risk assessments as red, green and amber and reviewed these ratings in the multidisciplinary meetings.
- Staff used 'the rating scale for aggressive behaviour in the elderly (RAGE)' across the wards and discussed this in multidisciplinary meetings. They reviewed this regularly.
- With one exception, staff kept blanket restrictions on the low secure and locked recovery wards to a minimum. Staff posted clear notices on the wards for patients explaining why these restrictions were in place. We did note, however, that none of the wards permitted patients to make their own hot or cold drinks. There were no facilities available for patients to make their own drinks or prepare a snack.
- Staff told us that, where they identified particular risks, they safely managed these by putting in place relevant measures. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments we reviewed took account of patients' previous risk history as well as their current mental state.

Forensic inpatient/secure wards

- We spoke with staff about protecting their patients from abuse. All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns they had. All staff had received training in safeguarding vulnerable adults and children and were aware of the organisation's safeguarding policy. We noted that in the preceding year 34 safeguarding concerns were raised, all currently closed. We spoke to the safeguarding lead for St Magnus Hospital who acted as a resource of information for staff and as an advisor for any safeguarding concerns raised. The lead told us about audits that they carried out to make sure systems were working well.
- We checked the management of medicines on all the wards and looked at 12 medication administration records (MARs). There were no errors. The medicines were stored securely on all the wards we visited. Daily checks were made of room and refrigerator temperatures to ensure that the medicines remained suitable for use. We saw the records kept. Appropriate emergency medicines and equipment were available on all wards and we saw that they were checked regularly to ensure they were in date and suitable for use. All medicines needed were available. We looked at the ordering process and saw the process for giving patients their regular medicines and we heard from patients about the information they were given. A pharmacist visited the hospital every other week and we saw evidence of the checks and interventions that they made during their visits. The pharmacist fed back information to the nurses and doctors each week. The nurses and doctors took any necessary action promptly. For example, the pharmacist said staff should not put inserts in the controlled medicines book. If there was an error, staff could add an explanatory note. All the records we looked at showed staff frequently reviewed medicines.
- Staff gave patients information about medicines. Staff discussed medicines in a multidisciplinary care review. Staff discussed changes to the patients' medicines with them and provided leaflets with more information. We saw this happening during our inspection.
- Staff used clear protocols and processes for patients to see children from their family. Each request was risk assessed thoroughly to ensure a visit was in the child's best interest. Separate and secure family rooms were available away from the ward areas in the main building. Staff had decorated and furnished this room to a high standard.

Track record on safety

- The provider's incident records for St Magnus Hospital for the quarter April to June 2015 reported five incidents of patient-to-patient verbal and physical abuse and two of patients who had acquired unexplained physical injuries. Staff told us that they learnt from incidents, for example increasing staff presence in communal areas of the wards to observe that patients were interacting with one another safely.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the provider's paper-based recording system. All incidents were rated green (low-grade incident), amber (moderate-grade incident) or red (high-grade incident) when being reviewed by ward managers and then forwarded to the hospital manager. Ward managers investigated all green-rated incidents and staff sent copies of all incidents to the clinical governance team. Staff told senior managers within the organisation about incidents in a timely manner so that they could monitor the investigation and respond to these. The clinical governance team analysed recommendations from all incidents and reported these back quarterly to the wards for discussion in team and service-wide meetings. Staff investigated all incidents to try to establish the root cause.
- Staff told us that they received feedback from investigations in regular team meetings and that they learnt key themes and lessons and developed action plans if they needed to make changes. Staff said there was always a debrief session arranged, after an incident, and that a facilitated, reflective session would take place to ensure, as well as learning lessons, that staff felt adequately supported.
- The clinical governance team circulated quarterly reports to the wards with incident summaries for each ward and emerging themes. There was a section detailing key lessons for learning in order to prevent

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reoccurrence of the incident. For example, we saw that work was under way to improve staffs' awareness of restrictive practices and that the seclusion policy was being rewritten to provide more clarity.

- Senior managers discussed incidents in the weekly senior managers' meeting and we saw this when we looked through the minutes of the meeting.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff assessed patients' needs and delivered care in line with the patients' individual care plans. All patients received a thorough physical health assessment, and staff identified and managed risks to physical health. We saw that in addition to psychiatrists working as part of the multi-disciplinary teams, general practitioners (GPs) visited the hospital regularly every week. Care plans were available for those patients with an identified risk associated with their physical health. We looked at one care plan developed for risks associated with poor mobility and the potential risk of falling. Physiotherapists advised on the development of care plans and included advice on the use of mobility aids and training to strengthen the patient's balance and gait. Care plans used the National Institute for Health and Care Excellence (NICE) guidance for the assessment and prevention of falls in older people. The hospital had many dual qualified nurses in both physical health and mental health. All staff we spoke to were very confident in their ability to assess physical health care needs and provide robust care and treatment plans.
- Care plans were personalised, holistic and recovery focused. All wards used the care programme approach as the overarching method for planning and evaluating care and treatment. Wards used a nationally recognised good practice recovery tool called, 'my shared pathway'. This process focussed on a patient's strengths and goals. The approach is a way of planning, following and managing an admission through secure services, looking at recovery, health, relationships, safety and risk. Staff had fully implemented the approach. This enabled a consistent approach during assessment, implementation and evaluation of patient's care and treatment. In a minority of cases there was no reference made to the patient's involvement. We spoke to patients about the care planning process, received mixed views and feedback about how recovery focussed their plans were, and whether they were encouraged to be fully involved in planning and evaluating care and treatment. We saw many examples of staff applying this individualised approach to patients. All of the clinical meetings we attended discussed the patients as individuals with unique needs. For example, staff told us about one patient who had recently lost weight. Staff gave him his favourite food to stimulate his appetite and in turn eat more and gain weight. We saw another example of how staff asked a patient's family about his interests and hobbies. We saw that the staff purchased books about the identified hobbies in an attempt to engage the patient in a topic meaningful to him.

Best practice in treatment and care

- Staff used National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines, in relation to the care, treatment and wellbeing of older adults and in assuring the highest standards of physical health care.
- Patients had access to a variety of psychological therapies either on a one to one basis or in a group setting, as part of their treatment and psychologists, physiotherapists, speech and language therapists, occupational therapists and activity co-ordinators were part of the multi-disciplinary team and were actively involved. We saw evidence of detailed psychological assessments and assessments of neuropsychological functioning. We noted specific psychological therapy work was available for a variety of offending behaviour.
- GPs attended all of the wards on a weekly basis and provided physical health advice and consultancy for patients. Regular physical health checks were taking place for all of the patients on every ward.
- We saw evidence on all of the wards of adherence to the Department of Health (2010) requirements that venous thromboembolism (VTE) risk assessments took place for every patient. We saw that the practice adhered to the NICE (2010) recommendations on VTE risk assessments.

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- Staff used the malnutrition Universal Screening Tool (MUST) for all patients and developed care plans where appropriate.
- The provider used the NHS safety thermometer, which provided a method for surveying patient risks and harms. This enabled the provider to analyse results and monitor patient safety data in order to provide care free from harm. For example, the improvement tool records all potential occurrences of pressure ulcers, infections and falls.
- Occupational therapy assessment and outcome measures were in place for all patients.
- Staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These covered twelve health and social domains and enabled clinicians to build up a picture overtime of their patients' responses to interventions.
- Staff participated in clinical audits to monitor the effectiveness of services provided. We saw that all staff participated, at least weekly, in reflective practice sessions. They evaluated the effectiveness of their interventions. Audits included reviewing adherence to annual physical health checks for patients, reviewing adherence to the CPA policy and associated risk assessments, crisis and contingency planning, ensuring good practice in prescribing and management of medication, adherence to the Mental Health Act Code of Practice and evaluating the effectiveness of a variety of health and safety practices and protocols.
- A quarterly clinical governance meeting was held where discussion on clinical effectiveness, patient safety and patient experience were held. Representatives from all wards were at the meeting.

Skilled staff to deliver care

- The staff on all of the wards came from various professional backgrounds, including medical, nursing, social work, speech and language therapy, dementia specialists, older age specialists, psychology, occupational therapy and physiotherapy.
- Staff received appropriate training, supervision and professional development. 91% of staff had received mandatory training and updates. Staff were also encouraged to attend longer internal and external training courses. Opportunities to undertake a dual qualification in mental health nursing were available for nurses. Student nurses were encouraged to apply for substantive positions. Staff were offered educational packages to suit their individual needs and interests. Wide varieties of diploma and masters level courses were available to all staff, including qualifications in dementia and palliative care. The provider had implemented a certificate of care training for all new staff. Mentorship and preceptorship programmes were available to staff. English language classes were available for all staff that did not have English as a first language. We saw that ancillary staff received a wide range of training, for example, medical staff held briefing sessions on dementia, older age mental health and Huntington's disease. In addition, we saw that the provider had strong links to Kingston, Portsmouth, Surrey and Kings College universities. The professional development opportunities and support offered to all staff at St Magnus hospital made a strong and positive impression on our team.
- We attended a training session with a group of new employees undergoing their induction. The 12-week induction programme was detailed, thorough and comprehensive. New employees said they found the induction programme particularly helpful in preparing them to provide high-quality care and the calibre of training staff was exceptional.
- All staff we spoke to said they received individual and group supervision on a regular basis as well as an annual appraisal. All staff participated in regular reflective practice sessions where they were able to reflect on their practice and incidents that had occurred on the wards. We noted that 92% of all staff had received an appraisal, which is a good level of attainment.
- All wards held a regular team meeting and all staff described morale as good with their team managers being highly visible, approachable and supportive.
- All wards had multidisciplinary team away days and that regular manager workforce development groups took place facilitated by the hospital manager. Topics recently covered included managing and learning from incidents, duty of candour, care planning and reducing restrictive practices.
- Following the most recent staff survey, the organisation developed a set of objectives to improve staff experience of working at St Magnus. This included giving staff more feedback on the outcomes from accident and

incident investigations, developing strategies to better support staff against bullying by patients and to take note that staff have feedback that at times they experience work-related stress.
- Senior managers told us they were performance managing a small number of capability issues at the time of our inspection.

Multidisciplinary and inter-agency team work

- Fully integrated and well-staffed multidisciplinary teams worked on the wards. Regular and fully inclusive team meetings took place. We observed care reviews and clinical handover meetings on most wards. We found these to be highly effective, and saw they involved the whole multidisciplinary team. Staff had space and time to feedback and add to discussions in meetings.
- We observed interagency working taking place. Staff from local primary care services visited the hospital regularly, such as a diabetic nurse specialist and a tissue viability nurse specialist.

Adherence to the MHA and the MHA Code of Practice

- We noted that 75% of staff had received updated training on the Mental Health Act.
- We carried out a full Mental Health Act review on Sycamore ward, which included examining all the documentation for those patients. We also reviewed some documentation on all of the other wards.
- The provider could demonstrate that there was a process in place to ensure that the operation of the Mental Health Act met legal requirements. Staff had implemented regular ward audits of Mental Health Act paperwork and this enabled staff to ensure they met the requirements of the Act. We found that detention papers were available for review and were in good order throughout.
- Staff had explained to patients their rights and at appropriate times. If they had declined to engage in a discussion this was noted and repeat attempts undertaken. Staff repeatedly tried to ensure patients received their rights.
- Care plans were holistic and detailed. There were some very good recording of patients' views about their care but in a minority of cases, there was no evidence of patient involvement. We acknowledge that some patients might not be able to participate in discussions about their care, but we were unable to find a record of where this was the case.
- Patients were given information so that they could participate in decisions where possible. The ward admission pack included information about ward systems and the patient's care plan. We saw in the care records that each patient had been given this.
- In response to a request raised through the 2013/14 family satisfaction survey an information provision system had been developed. This provided both the patient and their identified relative with written information to help them better understand the Mental Health Act and the patients' care within a low secure psychiatric hospital setting. A control spreadsheet was in place to record the distribution of a range of useful leaflets, some in easy read format, where appropriate, to patients and their relatives.
- The system for recording leave was systematic and thorough. All out of date leave forms had been crossed through and there was evidence that patients had been offered a copy of their authorisation.
- There were detailed assessments of capacity to consent to treatment. Authorisations for urgent treatment under section 62 were completed appropriately, as were requests for a review from a second opinion appointed doctor (SOAD).

Good practice in applying the MCA

- A total of 87.5% of staff had undertaken Mental Capacity Act (MCA) training. There was an MCA policy in place and staff were able to tell us about the principles and how they applied to their patients.
- Where appropriate patients had a mental capacity assessment relating to care and treatment. We also saw this reflected in care plans and additional assessments for specific interventions such as medical procedures and personal care delivery.
- We saw staff practicing the principles of the MCA during activities and over meal times, assisting patients to make decisions about their meals and how or where they would like to eat.

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- We saw documentation around best interest decisions in patient's notes and staff were able to articulate what this meant.
- The clinical governance department and the Mental Health Act administrator monitored adherence to the MCA and DoLS.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- Almost all patients we spoke with complimented staff providing the service on all wards, even when restrictions to their care and treatment were in place. Kind and respectful staff supported patients consistently.
- Patients we spoke with told us that staff were always available and that they did not spend long periods of time in the nursing office. We saw this was the case during our inspection. Patients commented on the compassion and care shown to them by staff. Patients told us that staff were consistently respectful towards them. For example, several patients we spoke with told us that staff would always knock on their bedroom doors and wait for a response before entering.
- Staff showed patience and gave encouragement when supporting patients. We observed this consistently on all of the wards we visited throughout the inspection.
- Despite the complex, and, at times challenging needs of the patients using the service, the atmosphere on all of the wards was very calm and relaxed.
- We saw staff were particularly calm and not rushed in their work so their time with patients was meaningful. Staff were able to spend time individually with patients, talking and listening to them. We did not hear any staff, on any of the wards ask a patient to wait for anything, after approaching staff.
- During our inspection, we saw a lot of positive interaction between staff and patients on the wards. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time. We saw, for example in clinical meetings, that staff were open and honest with patients and that this contributed to effective communication.
- All staff we spoke with had a very in-depth knowledge about their patients including their likes, dislikes and preferences. They were able to describe these to us confidently, for example, preferred food for patients.
- We observed a number of swift interactions where staff saw that patients were becoming agitated, distressed or overly stimulated, particularly with visitors on the wards. We saw staff immediately attended to their patients in a kind and gentle manner.
- We received many commendations by both patients and relatives about individual staff on all of the wards. Comments about them included them being particularly kind and perceptive.
- All relatives, with one exception, were positive about how excellent the staff were. They told us how caring and professional the staff were. Staff went to great lengths to welcome relatives and to facilitate enjoyable and quality time with patients. We spoke with one relative, in a clinical meeting who said that their relative had never been so well, for many years and that this in part was due to the respectful and caring approach of the staff. The relationship developed between their relative and staff was, they said, based on mutual trust and had led to the complete absence of any conflict, which had figured highly with their relative previously.
- Staff gave many examples of their strong understanding of and implementation of respectful relational security. They were able to describe situations where de-escalation techniques and a respectful approach had been successful and had promoted reduction in use of restraint. Staff we saw were consistently respectful in their communication with patients.

The involvement of people in the care they receive

- Staff were able to discuss with confidence their approach to patients and the model of care practiced across all of the wards and the care pathway. They spoke about enabling patients to take responsibility for their care pathways. Where patients were not able to take part in an active way, staff told us how they gently

introduced choice and preferred options for patients. We saw that staff were non-judgemental towards their patients and empowered them to encourage their involvement.

- Patients received a comprehensive handbook on admission to the wards. The handbook welcomed patients and gave detailed information. This included information about health needs, the multidisciplinary team, care and treatment options, medication and physical health needs, arrangements for health records, my shared pathway and treatment, daily life on the ward, recreation and leisure needs and options, health and safety, communication, visits, rights, advocacy, diversity needs and any questions patients may want to have answered. We found the handbook helped to orientate patients to the service and patients we spoke to had received a copy and commented on it positively.
- There was evidence of patient involvement in the care records we looked at, although, where patients were unable to participate this was not always recorded. We saw that the shared pathway documentation was available on the electronic care records system. We noted this approach was person centred, highly individualised and recovery orientated. We also saw that all patients reviewed their care plan at least once every two weeks with the multi-disciplinary care team and at least once each month with a member of the ward nursing team.
- All the wards displayed information about local advocacy services.
- Staff discussed patients' views and wishes with them. During our inspection, we saw a number of multidisciplinary care review meetings where we saw this happening. At all the meetings, staff gave patients options to consider for treatment and therapy. We saw that relatives were actively encouraged to attend these meetings and that their contributions were highly valued by patients and staff.
- All patients were encouraged to plan for ward round meetings by completing a patient feedback template.
- Patients could get involved through a number of initiatives. This included the hotel services meeting where the head of housekeeping and head chef met with patients on the wards to elicit feedback about the quality of the services and to hear feedback and suggestions for improvement from patients and ward staff.

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

Good 

Access and discharge

- Oak ward provided a service for patients with significant cognitive impairment, challenging behaviour and serious physical health problems. Sycamore ward offered an initial assessment and intensive care/ high dependency ward. Willow ward offered a service to patients with functional mental ill health and personality disorder but with little or no cognitive impairment.
- Key clinical and managerial staff, attended a bed management and referrals meeting and the hospital medical director chaired the meeting. This meeting oversaw the inpatient secure, locked recovery and nursing home care pathway. In this meeting, all current bed occupancy was scrutinised as well as transitions into, through and move on from the service. The bed management meeting monitored and tracked appropriate bed usage and identified any pressures in the system. Staff considered whether patients were suitable for move on to the Rosemary park nursing home.
- St Magnus admitted patients from more than 25 clinical commissioning groups as well as from NHS England. We spoke to staff about ensuring good, clear communication with the various commissioners and indeed families of patients who often lived some considerable distance from the hospital. Staff told us about innovative and creative plans which had been put in place to facilitate and enable contact with families. Once consent had been given by a patient, staff would arrange transport and hotels for relatives to enable a visit. We saw one example of a family travelling from another continent to see their relative, facilitated by the multidisciplinary team.

Forensic inpatient/secure wards

- The bed management meeting monitored all actual and potential inpatient delayed discharges. We noted that there were no reported delayed discharges.
- We spoke with patients who had progressed through the secure care pathway. Some came from prison or medium secure services. One patient told us how unwell he had been on admission to St Magnus and how, two years on, he had been discharged from his section of the Mental Health Act and had moved to a supportive community placement.

The facilities promote recovery, comfort, dignity and confidentiality

- All of the wards had a full range of rooms and equipment to support care and treatment delivery. With the exception of Oak ward, which was due a full refurbishment within a two-month period, the remaining wards had a high standard of environment and provision with quiet spaces to use, therapy rooms, sensory rooms, large en suite bedrooms, personalised where requested and visitor rooms all attractively and creatively furnished. The design and standard of the newly built and refurbished wards were excellent.
- The wards had access to very well resourced occupational therapy areas. Patients were encouraged to leave the ward areas during the day to attend the occupational therapy facilities with staff.
- Each of the new build wards had access to a telephone built into a communal corridor wall, with a privacy hood above the telephone. While positive in that there was a direct outside line, which was free of charge to patients, the telephone had no handset and operated as a loud speaker so that it would not be possible to hold a private conversation. Three patients commented on the inability to have a private conversation on these telephones. Staff told us that patients could request a cordless office phone to use in one of the quiet rooms if they wanted to make a private phone call.
- Each ward had access to large outside gardens, all within the perimeter fence. We looked at an area called the wildlife garden, which was accessible to all wards within the perimeter fence. This area had been planted attractively and we saw that a variety of horticultural endeavour was underway, led by both clinical staff and patients. We saw a permanent gazebo/ summerhouse there, with a café. On the day of our inspection, an external entertainer was singing for and with patients. All patients were able to enjoy the outside facilities, many with staff supervision, as the perimeter secure fence was on the outside of all available space.
- All of the patients we spoke to commented positively about the quality and variety of food served. We were told that if patients had specific dietary requirements or preferences that a chef would visit the ward to speak directly with the patient. The chef held regular meetings with patients to hear feedback about the food provided and encouraged suggestions for improvements.
- There were no facilities available on any of the wards for patients to make cold or hot drinks or to have snacks throughout the night and day. Patients could ask for drinks, which staff would make, and staff offered drinks and snacks to patients at regular intervals during the day. When we asked a variety of staff about this blanket restriction, we received mixed views. Some staff commented on the level of risk which would be introduced if patients had access to hot water, other staff viewed the restriction as patronising, de-skilling and institutional. This approach was not in keeping with an individualised and enabling culture we saw in other areas of the service provided. We discussed this with the hospital managers who agreed to review this restriction.
- Patients were encouraged to personalise their bedrooms and the communal areas of the wards. Patients showed us around some bedrooms and we could see that they had created a homely environment, if they wanted to. All of the wards and the communal areas throughout St Magnus had enhanced the environment with the use of soft furnishings and pictures to an exceptionally high standard. Some areas, for example the visiting rooms, reception areas and sensory rooms were quite remarkable and striking in their design and degree of comfort afforded.
- All patients, if they could do so, had an electronic wrist fob to gain access to and lock their bedrooms and could gain access at any time. Patients were all able to store their possessions securely.
- Daily and weekly activities were advertised and available on and off all wards. An excellent range of activities and groups was available to patients on all of the wards, facilitated by the activity co-ordinators and ward staff. The activities were varied, recovery focused

and aimed to motivate patients. Patients were actively encouraged to make suggestions for activities they would like. Sessions were available on a wide variety of skills based learning and included emotional literacy, balance improvement, falls prevention, social skills training, fun activities and creative groups. During our inspection, we joined a number of these activities and found them inclusive, creative and enjoyable.

- We saw examples of activities undertaken by patients and we discussed these with them. Examples included; watching films, healthy eating, current affairs, walks around the hospital and local area, gardening projects, computer courses, cookery classes, relaxation, music appreciation, art and poetry and much more. Many activities involved ward staff and we found all staff motivated and driven to embrace the recovery based approach. We were particularly pleased to join patients at a visiting petting zoo session. We saw that patients were able to connect positively with staff while watching and touching some of the animals. We saw one patient smiling and stimulated by the animals. The patient had appeared uninterested and withdrawn on the ward earlier in the day.
- Occupational therapy was available across all wards and a variety of therapy sessions was available on all wards. We saw they operated a model, which focused on a holistic, person-centred and recovery-based approach.
- A dedicated gym instructor provided group and individual activities. We saw the well-equipped gym and heard that patients all received an induction and personalised plan. Only one staff member had the necessary training to use the gym. Patients could therefore only use the gym when that staff member was on duty and not at any other time, for example evenings or weekend periods.

Meeting the needs of all people who use the service

- All of the wards had full disability access.
- Staff respected patients' diversity and human rights, and asked about people's cultural, language and religious needs at admission. Contact details for local faith representatives were available. Patients used the sensory rooms in both the low secure and locked recovery areas as multi faith areas. We discussed the facilities with staff and noted that there were no holy books or prayer mats available for use. Staff said that if a patient required these, then they could have them, but we saw no reason why the items could not have been stored in one of the available cupboards in the rooms, which otherwise had a high standard of furnishing.
- Interpreters were available and used, when required. Leaflets were available explaining patients' rights under the Mental Health Act.
- There was up to date and relevant information on the wards and in communal areas which included information for visitors, contact details and information on advocacy, information on mental health problems and available treatment options, local services for example on benefits advice and how to raise a concern or make a complaint.
- All wards had an extensive variety of books, games, puzzles, CDs and DVDs, all on show and available to patients at any time.
- A choice of meals was available. A varied menu enabled patients with particular dietary needs connected to their religion or culture, and others with particular individual needs or preferences, to eat appropriate meals. A chef was readily available to speak to any patient with specific dietary requests or preferences.

Listening to and learning from concerns and complaints

- There were 24 formal complaints in the 12 months preceding the inspection for the whole of St Magnus Hospital. The provider upheld eleven of these, which showed us that the provider was fair and transparent when dealing with complaints.
- Copies of the complaints process were on display in all of the wards and in the ward information handbooks. Patients and their relatives we spoke with all knew how to make a complaint should they wish to do so.
- Staff confidently described the complaints process and how they would handle any complaints. Staff told us that they try to deal informally with concerns and to do this promptly in an attempt to provide a timely resolution to concerns.
- Senior staff met regularly with the clinical governance team to discuss learning from complaints. This informed

a programme of improvements and training, for example labelling patients' property clearly to avoid misplacing items and briefing sessions for staff on duty of candour.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

- The provider's vision, values and strategies for the service were evident and on display in all of the wards. Staff on the wards understood the vision and direction of the organisation. Staff at every level felt very much a part of the service and were able to discuss the philosophy of the hospital confidently.
- The ward managers had regular contact with the hospital manager, medical director and the hospital director. The senior management and clinical team were highly visible and staff said that they regularly visited the ward, usually every day.
- Good administrative support was provided from the clinical governance team and the ancillary services such as housekeeping, catering, transport, human resources, the education centre, administration and maintenance departments.
- We heard excellent feedback about the senior clinical leads and the director responsible for St Magnus. Staff said that the senior management team had great experience and they could ask them about any matter at any time. Staff were confident the response would be proactive and responsive.

Good governance

- The wards had access to systems that enabled staff to monitor and manage the wards effectively, and provided information such as incident reporting, management of complaints, and human resource information about staff and their training to senior staff in a timely manner. However, we noted that there was little formal information on controls either expected or produced. Managers told us that as the services are on one site and given that the business and clinical governance teams were readily available, that this was sufficient mitigation. We noted however that there was no risk register available either singularly for each ward or severally for the hospital. Ward managers could talk about the risks but there was no single system for listing or reporting them. We saw no performance dashboards or key performance indicator framework available for the ward managers or their wards. This meant there was a chance of under- reporting and underperformance, which could have gone unchecked. We raised this with senior managers as we determined that there was no formal method of managing expected performance or dealing effectively with any underperformance.
- We noted that the ward managers did not manage any aspect of the ward budgets. The ward managers told us that the hospital manager and director controlled all financial management processes. Managers told us that all requests, within reason, for additional resources were met positively by their senior managers. Senior managers also told us that they did not ask ward managers to carry out this task to avoid reducing the time they had available for patients and staff on the wards.
- All ward managers told us that they were encouraged by their managers to work autonomously in managing their wards and received excellent support from the hospital manager, medical director and the service director.

Leadership, morale and staff engagement

- Ward managers were in post and led the wards well. The ward managers were visible on the wards during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support. Staff told us that the culture on the wards was open and encouraged them to bring forward ideas for improving care, which we sampled.
- All of the ward staff we spoke to were enthusiastic and engaged with developments on the wards. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident their line managers would listen to them. Some staff gave us examples of when they had spoken out with concerns about the care of people and said managers received this positively as a constructive challenge to ward practice.

Forensic inpatient/secure wards

- Staff told us that staff morale was “very good” and observations throughout our inspection confirmed this.
- All wards took time out to attend multi-disciplinary away days.
- Sickness and absence rates were very low at 1.2%.
- Staff were aware of the whistleblowing process if they needed to use it.

Commitment to quality improvement and innovation

- Accredited members of the Royal College of Psychiatrists quality network for low secure mental health services. (March 2015)
- Staff participated in wide range of clinical audits to monitor the effectiveness of services provided. We saw that all staff participated, at least weekly, in reflective practice sessions to evaluate the effectiveness of their interventions. Audits included reviewing adherence to annual physical health checks for patients, reviewing adherence to the CPA policy and associated risk assessments, crisis and contingency planning, ensuring good practice in prescribing and management of medication, adherence to the Mental Health Act Code of Practice and evaluating the effectiveness of a variety of health and safety practices and protocols.

Long stay/rehabilitation mental health wards for working age adults

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

Information about the service

St Magnus Hospital has three locked recovery wards for men only. The hospital specialises in the care and treatment of older adults and has a capacity for 42 patients. Cowdray, Petworth and Park House wards are locked recovery wards with eight, 16 and 18 beds respectively.

- Cowdray ward offered eight beds in a locked recovery ward for initial assessment in an intensive care/ high-dependency ward.
- Petworth ward offered services to 16 patients who suffered from mental ill health and/or personality disorder but with little or no cognitive impairment.
- Park House offered a service to 18 patients experiencing marked cognitive impairment, challenging behaviour and serious physical health problems.

Summary of findings

We rated St Magnus Hospital as **good** because:

Staff kept wards safe and clean and patients said they felt safe. There were enough suitably qualified and trained staff to provide care to a good standard. Staff kept person-centred patient risk assessments and formulations, which are plans to reduce risk. The service had clear ways to report any incidents which occurred and staff learnt lessons when things went wrong.

Nursing and medical staff assessed patients' needs effectively, planned their care thoroughly and individually, and focused on recovery. Physical health care assessments and associated plans of care were thorough and consistently delivered to a high standard. There was evidence of best practice and all staff understood the Mental Health Act 1983 (MHA), the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and the associated Codes of Practice. Throughout all of the wards, multidisciplinary teams consistently and proactively supported a high standard of patient care. The training and professional development opportunities offered and taken up by all staff was exemplary as all staff told us their training needs were appropriately accommodated.

We consistently saw caring, respectful, patient, responsive and kind interactions between staff and patients. All relatives and carers we spoke to, with one exception, said how caring and compassionate staff were towards them and the patients. The staff used

Long stay/rehabilitation mental health wards for working age adults

innovative practices consistently, to engage and involve patients in their care and treatment. Staff we spoke with were confident and understood how the relationship they had with patients affected a safe environment.

Staff managed the use of beds to meet people's needs and had strong relationships with many commissioners. Staff provided the service in a way that optimised patients' recovery, comfort and dignity. There was a varied, strong and recovery-orientated programme of therapeutic activities. The service responded to patients' and relatives' concerns or ideas to improve services. Staff listened to ideas and put them in place. The newly built and refurbished wards were provided to an excellent design and standard. In the wildlife garden the provider had gone beyond expectations to benefit patients and staff, by providing a remarkable and extraordinary environment. All patients could enjoy the outside facilities.

Staff told us that they had good morale and felt well supported and engaged with a highly visible and strong leadership team, which included both clinicians and managers. Staff at every level felt a part of the service and could discuss the hospital's philosophy confidently. Managers maintained strong controls to know that all was well but did not always formally set these out or record them, such as in performance dashboards or a risk register.

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

Good

Safe and clean environment

- Staff provided physical and procedural security consistently and to a good standard. Staff used policies and procedures to ensure the safety of patients, visitors and staff. There were a range of effective procedures across the service that enabled staff to establish and maintain clear boundaries across the site.
- There was a single main entrance to enter and exit the hospital with a comfortable reception area, furnished to a high standard and well equipped with soft furnishings. The entrance environment for patients, visitors and staff was welcoming, with comfortable furniture, lockers for storing personal belongings, cold water to drink, bathroom facilities, and a variety of relevant leaflets and information. Reception staff were professional and managed the area efficiently. Park House was separately located on the wider hospital site.
- All areas of the hospital were within the secure perimeter fence and patients and staff had easy access into the wildlife garden.
- We saw that, although Park House was located away from the other wards, it too had a secure perimeter fence with direct access to its own garden area and the wildlife garden.
- The layouts of the wards enabled staff to observe the majority of the ward areas. Where observation was restricted, we saw that staff put risk mitigation plans in place. Closed-circuit TV (CCTV) was available in all communal areas of all of the wards. Viewing panels in bedroom doors were not available on all of the wards. This meant staff had to open bedroom doors for day and night observation checks, with the possibility of disturbing the sleep of patients. All staff wore a wrist fob, which enabled access to all areas. Where it was possible, patients had a fob to their bedroom to enable access at times of their choosing.

Long stay/rehabilitation mental health wards for working age adults

- All wards had ligature risk assessments. Staff had taken specific action to mitigate the risks identified.
- All wards were gender specific and male only.
- Emergency equipment was stored in all wards in the nursing offices. A well-equipped clinical room was available. Park House used the nursing office or patients' bedrooms for individual examination where required. An automated external defibrillator and anaphylaxis pack were in place. Staff checked emergency equipment weekly to ensure it was fit for purpose and would be effective in an emergency. Staff were trained and able to respond to any physical health emergencies.
- None of the wards had a seclusion room.
- The provider had refurbished Cowdray locked recovery ward to a high standard. Petworth ward was due further refurbishment but was maintained to a good standard. All en suite bedrooms were of a generous size.
- Staff maintained and cleaned all the wards to a good standard throughout. The provider had provided good quality furniture, fixtures and fittings. Staff conducted regular audits of infection control and prevention and staff hand hygiene to ensure protection for patients, visitors and staff against the risks of infection. Staff said that when they reported a fault or issue, the maintenance team responded promptly and effectively. Cleaning schedules were available in all areas.
- The staff carried out a range of environmental and health and safety audits. These included risk assessments and checks on standards of cleanliness.
- Alarms were available in each room on the wards and all staff carried alarms. Staff said they responded quickly to any alarms sounded.
- All wards took part in regular health and safety meetings and we looked at the minutes of these meetings.

Safe staffing and key staffing indicators

- Across St Magnus Hospital and Rosemary Park Nursing Home the establishment for substantive staff was 144 whole time equivalents. There was a projected 15% vacancy rate for St Magnus Hospital at the time of the inspection based on the staffing requirements for the new wards then being opened and enhanced staffing calculations for existing wards. There was a review of safe staffing levels and an increase in staff in May 2015 in order to ensure safe staffing of the newly reconfigured low secure and locked recovery wards. Staff were actively recruiting to fill these vacancies. Temporary staff filled 277 shifts in the period 1/03/2015 to 31/05/2015 in St Magnus Hospital, many to meet additional staffing requirements arising from increased patient needs such as one to one nursing and hospital appointment escorts, and no shifts were left uncovered. The annual sickness rate was low at 1.2% and the staff turnover rate was 10%.
- All the staff we spoke to said there were sufficient staff to deliver care to a good standard. Administrative staff were in place, to provide effective governance processes and support to clinical staff. This support enabled clinical staff to have time released to be able to prioritise the care and treatment of their patients.
- All the patients we asked said that they felt safe at St Magnus Hospital.
- We looked at six staff recruitment files and found them completed appropriately and to a good standard. Staff had carried out all the appropriate checks that should have been undertaken before new staff had started work. These included thorough identity checks, references, education certificate checks, completion of health questionnaires and satisfactory disclosure and barring service clearance (DBS).
- Ward managers and doctors told us that senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required. They gave an example where clinicians could enhance staff observation levels for patients when they were first admitted to the hospital to ensure safe and thorough risk assessing. On one ward, a recently admitted patient was on enhanced observation levels.
- The staff told us it was usually possible to escort patients on leave. Staff said they kept cancellation of escorted leave to an absolute minimum. They said if they did have to cancel leave, they routinely recorded this and escalated to senior managers.
- Patients received a one-to-one contact with a member of staff every day. We saw this recorded in the care records.

Long stay/rehabilitation mental health wards for working age adults

- Staff had trained in the use of physical interventions and staff on each shift were qualified registered general and mental health nurses. Many patients were frail and had physical health needs. There were sufficiently qualified staff available if required to assist.
- The wards had access to a wider multidisciplinary team, which included occupational therapists, psychologists, music therapists, art therapists, activity co-ordinators, a dementia nurse specialist, social workers, speech and language therapists and physiotherapists. The provider accessed specialist services when required, which included a tissue viability nurse, a diabetic nurse, chiropody, an optician and a dentist. Managers were available during night shifts. This showed us that the provider ensured a senior presence across a 24-hour period.
- Medical staff told us that there were adequate doctors available over a 24-hour period, seven days each week who were available to respond quickly on the wards in an emergency.
- In April 2015 staff had completed 91% of mandatory training.

Assessing and managing risk to patients and staff

- It was the provider's intention to manage behaviour without the use of seclusion. However the provider reported 18 incidents of seclusion using the latest Mental Health Act Code of Practice definition of seclusion, which took place in the past six months for very short periods of time and no incidents of long-term segregation. The highest number of 14 episodes of seclusion was on Petworth ward. There were 18 incidents of physical restraint. One of these was in the prone position and resulted in rapid tranquilisation. There was no seclusion room facility at St Magnus Hospital and staff said that on those occasions seclusion was required, the ward quiet rooms, sensory rooms and bedrooms were used. Staff told us that periods of seclusion lasted for minutes only as patients were easily distracted and calmed quickly. Staff told us that patients had significant levels of frailty and cognitive impairment and that they became less distressed if the short period of seclusion happened in their bedrooms. The provider had assessed that, given the added vulnerability of the patients at St Magnus, the use of a seclusion room would not be appropriate. At the time of our inspection, the provider was reviewing policies and protocols to reflect a range of restraint and seclusion practices.
- Staff practiced relational security to a good standard and they actively promoted de-escalation techniques to avoid restraints where possible. The policy document related to restraint techniques was 'the use and care of responsibility techniques', and all staff had been trained. Relational security is when staff use their knowledge and understanding of their patients to maintain a calm environment.
- We looked at 26 electronic care records across all the wards, including many for those patients detained under the Mental Health Act. The wards used an electronic care record system (CareNotes), which included the risk profile documentation. Staff carried out a comprehensive risk assessment for patients on their admission. Patients, where they had wanted to and had consented to, had been actively involved in the risk assessment process.
- Patients' risk plans were good and staff reviewed them regularly in multidisciplinary meetings. Staff used the care programme approach (CPA) to assist risk management processes. We saw evidence that staff used a structured decision support guide, called the historical clinical risk management -20 (HCR-20), to assess risk factors for violent behaviour. Staff rated patients' risk assessments as red, green and amber and reviewed these ratings in the multidisciplinary meetings.
- Staff used 'the rating scale for aggressive behaviour in the elderly (RAGE)' across the wards and discussed this in multidisciplinary meetings. They reviewed this regularly.
- With one exception, staff kept blanket restrictions on the low secure and locked recovery wards to a minimum. Staff posted clear notices on the wards for patients explaining why these restrictions were in place. We did note, however, that none of the wards permitted patients to make their own hot or cold drinks. There were no facilities available for patients to make their own drinks or prepare a snack. Petworth ward was about to start to risk assess patients for this purpose but this was not implemented at the time of our inspection.

Long stay/rehabilitation mental health wards for working age adults

- Staff told us that, where they identified particular risks, they safely managed these by putting in place relevant measures. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments we reviewed took account of patients' previous risk history as well as their current mental state.
- We spoke with staff about protecting their patients from abuse. All the staff we spoke with were able to describe what constitutes abuse and were confident in how to escalate any concerns they had. All staff had received training in safeguarding vulnerable adults and children and were aware of the organisation's safeguarding policy. We noted that in the preceding year 34 safeguarding concerns were raised, all currently closed. We spoke to the safeguarding lead for St Magnus Hospital who acted as a resource of information for staff and as an advisor for any safeguarding concerns raised. The lead told us about audits that they carried out to make sure systems were working well.
- We checked the management of medicines on all the wards and looked at 12 medication administration records (MARs). There were no errors. The medicines were stored securely on all the wards we visited. Daily checks were made of room and refrigerator temperatures to ensure that the medicines remained suitable for use. We saw the records kept. Appropriate emergency medicines and equipment were available on all wards and we saw that they were checked regularly to ensure they were in date and suitable for use. All medicines needed were available. We looked at the ordering process and saw the process for giving patients their regular medicines and we heard from patients about the information they were given. A pharmacist visited the hospital every other week and we saw evidence of the checks and interventions that they made during their visits. The pharmacist fed back information to the nurses and doctors each week. The nurses and doctors took any necessary action promptly. For example, the pharmacist said staff should not put inserts in the controlled medicines book. If there was an error, staff could add an explanatory note. All the records we looked at showed staff frequently reviewed medicines.
- Staff gave patients information about medicines. Staff discussed medicines in a multidisciplinary care review. Staff discussed changes to the patients' medicines with them and provided leaflets with more information. We saw this happening during our inspection.
- Staff used clear protocols and processes for patients to see children from their family. Each request was risk assessed thoroughly to ensure a visit was in the child's best interest. Separate and secure family rooms were available away from the ward areas in the main building. Staff had decorated and furnished this room to a high standard. We saw that the visiting room at Park House was part of the ward. However, staff told us about strict protocols used in the event of a child visiting to ensure the room was secure and not accessed for the duration of the visit.

Track record on safety

- The provider's incident records for St Magnus Hospital for the quarter April to June 2015 reported five incidents of patient-to-patient verbal and physical abuse and two of patients who had acquired unexplained physical injuries. Staff told us that they learnt from incidents, for example increasing staff presence in communal areas of the wards to observe that patients were interacting with one another safely.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the provider's paper-based recording system. All incidents were rated green (low-grade incident), amber (moderate-grade incident) or red (high-grade incident) when being reviewed by ward managers and then forwarded to the hospital manager. Ward managers investigated all green-rated incidents and staff sent copies of all incidents to the clinical governance team. Staff told senior managers within the organisation about incidents in a timely manner so that they could monitor the investigation and respond to these. The clinical governance team analysed recommendations from all incidents and reported these back quarterly to the wards for discussion in team and service-wide meetings. Staff investigated all incidents to try to establish the root cause.
- Staff told us that they received feedback from investigations in regular team meetings and that they

Long stay/rehabilitation mental health wards for working age adults

learnt key themes and lessons and developed action plans if they needed to make changes. Staff said there was always a debrief session arranged, after an incident, and that a facilitated, reflective session would take place to ensure, as well as learning lessons, that staff felt adequately supported.

- The clinical governance team circulated quarterly reports to the wards with incident summaries for each ward and emerging themes. There was a section detailing key lessons for learning in order to prevent reoccurrence of the incident. For example, we saw that work was under way to improve staffs' awareness of restrictive practices and that the seclusion policy was being rewritten to provide more clarity.
- Senior managers discussed incidents in the weekly senior managers' meeting and we saw this when we looked through the minutes of the meeting.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff assessed patients' needs and delivered care in line with the patients' individual care plans. All patients received a thorough physical health assessment, and staff identified and managed risks to physical health. We saw that in addition to psychiatrists working as part of the multi-disciplinary teams, general practitioners (GPs) visited the hospital regularly every week. Care plans were available for those patients with an identified risk associated with their physical health. We looked at one care plan developed for risks associated with poor mobility and the potential risk of falling. Physiotherapists advised on the development of care plans and included advice on the use of mobility aids and training to strengthen the patient's balance and gait. Care plans used the National Institute for Health and Care Excellence (NICE) guidance for the assessment and prevention of falls in older people. The hospital had many dual qualified nurses in both physical health and mental health. All staff we spoke to were very confident in their ability to assess physical health care needs and provide robust care and treatment plans.
- Care plans were personalised, holistic and recovery focused. All wards used the care programme approach as the overarching method for planning and evaluating care and treatment. Wards used a nationally recognised good practice recovery tool called, 'my shared pathway'. This process focussed on a patient's strengths and goals. The approach is a way of planning, following and managing an admission through secure services, looking at recovery, health, relationships, safety and risk. Staff had fully implemented the approach. This enabled a consistent approach during assessment, implementation and evaluation of patient's care and treatment. In a minority of cases there was no reference made to the patient's involvement. We spoke to patients about the care planning process, received mixed views and feedback about how recovery focussed their plans were, and whether they were encouraged to be fully involved in planning and evaluating care and treatment. We saw many examples of staff applying this individualised approach to patients. All of the clinical meetings we attended discussed the patients as individuals with unique needs. For example, staff told us about one patient who had recently lost weight. Staff gave him his favourite food to stimulate his appetite and in turn eat more and gain weight. We saw another example of how staff asked a patient's family about his interests and hobbies. We saw that the staff purchased books about the identified hobbies in an attempt to engage the patient in a topic meaningful to him.

Best practice in treatment and care

- Staff used NICE guidance when prescribing medicines, in relation to the care, treatment and wellbeing of older adults and in assuring the highest standards of physical health care.
- Patients had access to a variety of psychological therapies either on a one to one basis or in a group setting, as part of their treatment and psychologists, physiotherapists, speech and language therapists, occupational therapists and activity co-ordinators were part of the multi-disciplinary team and were actively

involved. We saw evidence of detailed psychological assessments and assessments of neuropsychological functioning. We noted specific psychological therapy work was available for a variety of offending behaviour.

- GPs attended all of the wards on a weekly basis and provided physical health advice and consultancy for patients. Regular physical health checks were taking place for all of the patients on every ward.
- We saw evidence on all of the wards of adherence to the Department of Health (2010) requirements that venous thromboembolism (VTE) risk assessments took place for every patient. We saw that the practice adhered to the NICE (2010) recommendations on VTE risk assessments.
- Staff used the malnutrition Universal Screening Tool (MUST) for all patients and developed care plans where appropriate.
- The provider used the NHS safety thermometer, which provided a method for surveying patient risks and harms. This enabled the provider to analyse results and monitor patient safety data in order to provide care free from harm. For example, the improvement tool records all potential occurrences of pressure ulcers, infections and falls.
- Occupational therapy assessment and outcome measures were in place for all patients.
- Staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These covered twelve health and social domains and enabled clinicians to build up a picture overtime of their patients' responses to interventions.
- Staff participated in clinical audits to monitor the effectiveness of services provided. We saw that all staff participated, at least weekly, in reflective practice sessions. They evaluated the effectiveness of their interventions. Audits included reviewing adherence to annual physical health checks for patients, reviewing adherence to the CPA policy and associated risk assessments, crisis and contingency planning, ensuring good practice in prescribing and management of medication, adherence to the Mental Health Act Code of Practice and evaluating the effectiveness of a variety of health and safety practices and protocols.
- A quarterly clinical governance meeting was held where discussion on clinical effectiveness, patient safety and patient experience were held. Representatives from all wards were at the meeting.

Skilled staff to deliver care

- The staff on all of the wards came from various professional backgrounds, including medical, nursing, social work, speech and language therapy, dementia specialists, older age specialists, psychology, occupational therapy and physiotherapy.
- Staff received appropriate training, supervision and professional development. 91% of staff had received mandatory training and updates. Staff were also encouraged to attend longer internal and external training courses. Opportunities to undertake a dual qualification in mental health nursing were available for nurses. Student nurses were encouraged to apply for substantive positions. Staff were offered educational packages to suit their individual needs and interests. Wide varieties of diploma and masters level courses were available to all staff, including qualifications in dementia and palliative care. The provider had implemented a certificate of care training for all new staff. Mentorship and preceptorship programmes were available to staff. English language classes were available for all staff that did not have English as a first language. We saw that ancillary staff received a wide range of training, for example, medical staff held briefing sessions on dementia, older age mental health and Huntington's disease. In addition, we saw that the provider had strong links to Kingston, Portsmouth, Surrey and Kings College universities. The professional development opportunities and support offered to all staff at St Magnus hospital made a strong and positive impression on our team.
- We attended a training session with a group of new employees undergoing their induction. The 12-week induction programme was detailed, thorough and comprehensive. New employees said they found the induction programme particularly helpful in preparing them to provide high-quality care and the calibre of training staff was exceptional.
- All staff we spoke to said they received individual and group supervision on a regular basis as well as an annual appraisal. All staff participated in regular reflective practice sessions where they were able to

reflect on their practice and incidents that had occurred on the wards. We noted that 92% of all staff had received an appraisal, which is a good level of attainment.

- All wards held a regular team meeting and all staff described morale as good with their team managers being highly visible, approachable and supportive.
- All wards had multidisciplinary team away days and that regular manager workforce development groups took place facilitated by the hospital manager. Topics recently covered included managing and learning from incidents, duty of candour, care planning and reducing restrictive practices.
- Following the most recent staff survey, the organisation developed a set of objectives to improve staff experience of working at St Magnus. This included giving staff more feedback on the outcomes from accident and incident investigations, developing strategies to better support staff against bullying by patients and to take note that staff have feedback that at times they experience work-related stress.
- Senior managers told us they were performance managing a small number of capability issues at the time of our inspection.

Multidisciplinary and inter-agency team work

- Fully integrated and well-staffed multidisciplinary teams worked on the wards. Regular and fully inclusive team meetings took place. We observed care reviews and clinical handover meetings on most wards. We found these to be highly effective, and saw they involved the whole multidisciplinary team. Staff had space and time to feedback and add to discussions in meetings.
- We observed interagency working taking place. Staff from local primary care services visited the hospital regularly, such as a diabetic nurse specialist and a tissue viability nurse specialist.

Adherence to the MHA and the MHA Code of Practice

- We noted that 75% of staff had received updated training on the Mental Health Act.
- The provider could demonstrate that there was a process in place to ensure that the operation of the Mental Health Act met legal requirements. Staff had implemented regular ward audits of Mental Health Act paperwork and this enabled staff to ensure they met the requirements of the Act. We found that detention papers were available for review and were in good order throughout.
- Staff had explained to patients their rights and at appropriate times. If they had declined to engage in a discussion this was noted and repeat attempts undertaken. Staff repeatedly tried to ensure patients received their rights.
- Care plans were holistic and detailed. There were some very good recording of patients' views about their care but in a minority of cases, there was no evidence of patient involvement. We acknowledge that some patients might not be able to participate in discussions about their care, but we were unable to find a record of where this was the case.
- Patients were given information so that they could participate in decisions where possible. The ward admission pack included information about ward systems and the patient's care plan. We saw in the care records that each patient had been given this.
- In response to a request raised through the 2013/14 family satisfaction survey an information provision system had been developed. This provided both the patient and their identified relative with written information to help them better understand the Mental Health Act and the patients' care within a low secure psychiatric hospital setting. A control spreadsheet was in place to record the distribution of a range of useful leaflets, some in easy read format, where appropriate, to patients and their relatives.
- The system for recording leave was systematic and thorough. All out of date leave forms had been crossed through and there was evidence that patients had been offered a copy of their authorisation.
- There were detailed assessments of capacity to consent to treatment. Authorisations for urgent treatment under section 62 were completed appropriately, as were requests for a review from a second opinion appointed doctor (SOAD).

Good practice in applying the MCA

Long stay/rehabilitation mental health wards for working age adults

- A total of 87.5% of staff had undertaken Mental Capacity Act (MCA) training. There was an MCA policy in place and staff were able to tell us about the principles and how they applied to their patients.
- There were 10 Deprivation of Liberty Safeguard (DoLS) applications in the previous six-month to June 2015, three on Cowdray ward and seven on Park House.
- Where appropriate patients had a mental capacity assessment relating to care and treatment. We also saw this reflected in care plans and additional assessments for specific interventions such as medical procedures and personal care delivery.
- We saw staff practicing the principles of the MCA during activities and over meal times, assisting patients to make decisions about their meals and how or where they would like to eat.
- We saw documentation around best interest decisions in patient's notes and staff were able to articulate what this meant.
- The clinical governance department and the Mental Health Act administrator monitored adherence to the MCA and DoLS.

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

Good

Kindness, dignity, respect and support

- Almost all patients we spoke with complimented staff providing the service on all wards, even when restrictions to their care and treatment were in place. Kind and respectful staff supported patients consistently.
- Patients we spoke with told us that staff were always available and that they did not spend long periods of time in the nursing office. We saw this was the case during our inspection. Patients commented on the compassion and care shown to them by staff. Patients told us that staff were consistently respectful towards them. For example, several patients we spoke with told us that staff would always knock on their bedroom doors and wait for a response before entering.
- Staff showed patience and gave encouragement when supporting patients. We observed this consistently on all of the wards we visited throughout the inspection.
- Despite the complex, and, at times challenging needs of the patients using the service, the atmosphere on all of the wards was very calm and relaxed.
- We saw staff were particularly calm and not rushed in their work so their time with patients was meaningful. Staff were able to spend time individually with patients, talking and listening to them. We did not hear any staff, on any of the wards ask a patient to wait for anything, after approaching staff.
- During our inspection, we saw a lot of positive interaction between staff and patients on the wards. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time. We saw, for example in clinical meetings, that staff were open and honest with patients and that this contributed to effective communication.
- All staff we spoke with had a very in-depth knowledge about their patients including their likes, dislikes and preferences. They were able to describe these to us confidently, for example, preferred food for patients.
- We observed a number of swift interactions where staff saw that patients were becoming agitated, distressed or overly stimulated, particularly with visitors on the wards. We saw staff immediately attended to their patients in a kind and gentle manner.
- We received many commendations by both patients and relatives about individual staff on all of the wards. Comments about them included them being particularly kind and perceptive.
- All relatives, with one exception, were positive about how excellent the staff were. They told us how caring and professional the staff were. Staff went to great lengths to welcome relatives and to facilitate enjoyable and quality time with patients. We spoke with one relative, in a clinical meeting who said that their relative had never been so well, for many years and that this in

part was due to the respectful and caring approach of the staff. The relationship developed between their relative and staff was, they said, based on mutual trust and had led to the complete absence of any conflict, which had figured highly with their relative previously.

- Staff gave many examples of their strong understanding of and implementation of respectful relational security. They were able to describe situations where de-escalation techniques and a respectful approach had been successful and had promoted reduction in use of restraint. Staff we saw were consistently respectful in their communication with patients.

The involvement of people in the care they receive

- Staff were able to discuss with confidence their approach to patients and the model of care practiced across all of the wards and the care pathway. They spoke about enabling patients to take responsibility for their care pathways. Where patients were not able to take part in an active way, staff told us how they gently introduced choice and preferred options for patients. We saw that staff were non-judgemental towards their patients and empowered them to encourage their involvement.
- Patients received a comprehensive handbook on admission to the wards. The handbook welcomed patients and gave detailed information. This included information about health needs, the multidisciplinary team, care and treatment options, medication and physical health needs, arrangements for health records, my shared pathway and treatment, daily life on the ward, recreation and leisure needs and options, health and safety, communication, visits, rights, advocacy, diversity needs and any questions patients may want to have answered. We found the handbook helped to orientate patients to the service and patients we spoke to had received a copy and commented on it positively.
- There was evidence of patient involvement in the care records we looked at, although, where patients were unable to participate this was not always recorded. We saw that the shared pathway documentation was available on the electronic care records system. We noted this approach was person centred, highly individualised and recovery orientated. We also saw that all patients reviewed their care plan at least once every two weeks with the multi-disciplinary care team and at least once each month with a member of the ward nursing team.
- All the wards displayed information about local advocacy services.
- Staff discussed patients' views and wishes with them. During our inspection, we saw a number of multidisciplinary care review meetings where we saw this happening. At all the meetings, staff gave patients options to consider for treatment and therapy. We saw that relatives were actively encouraged to attend these meetings and that their contributions were highly valued by patients and staff.
- All patients were encouraged to plan for ward round meetings by completing a patient feedback template.
- Patients could get involved through a number of initiatives. This included the hotel services meeting where the head of housekeeping and head chef met with patients on the wards to elicit feedback about the quality of the services and to hear feedback and suggestions for improvement from patients and ward staff.

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

Good

Access and discharge

- The locked recovery units offered initial assessment and intensive care/ high dependency services in Cowdray ward. Petworth ward offered services to patients who suffered from mental ill health or personality disorder, or both, but with little or no cognitive impairment. Park House offered a service to patients experiencing marked cognitive impairment, challenging behaviour and serious physical health problems.
- Key clinical and managerial staff, attended a bed management and referrals meeting and the hospital medical director chaired the meeting. This meeting

oversaw the inpatient secure, locked recovery and nursing home care pathway. In this meeting, all current bed occupancy was scrutinised as well as transitions into, through and move on from the service. The bed management meeting monitored and tracked appropriate bed usage and identified any pressures in the system. Staff considered whether patients were suitable for move on to the Rosemary park nursing home.

- St Magnus admitted patients from more than 25 clinical commissioning groups as well as from NHS England. We spoke to staff about ensuring good, clear communication with the various commissioners and indeed families of patients who often lived some considerable distance from the hospital. Staff told us about innovative and creative plans which had been put in place to facilitate and enable contact with families. Once consent had been given by a patient, staff would arrange transport and hotels for relatives to enable a visit. We saw one example of a family travelling from another continent to see their relative, facilitated by the multidisciplinary team.
- The bed management meeting monitored all actual and potential inpatient delayed discharges. We noted that there were no reported delayed discharges.
- We spoke with patients who had progressed through the secure care pathway. Some came from prison or medium secure services. One patient told us how unwell he had been on admission to St Magnus and how, two years on, he had been discharged from his section of the Mental Health Act and had moved to a supportive community placement. On Petworth ward patients told us that they appreciated the opportunity to exercise much more independence, despite still receiving treatment under the Mental Health Act and in some cases being restricted on hospital orders.
- Park House had a guest room available for the use of relatives and family members to use if they needed to stay overnight to be with their relative. We looked at this facility and found it comfortable and well furnished. The provider said that the room was free of charge to family members who might use it, for example, at the time of end-of-life care, or for more general visiting. We saw that this facility enabled people to spend more time with their relatives and that the provider was very flexible around its usage.

The facilities promote recovery, comfort, dignity and confidentiality

- All of the wards had a full range of rooms and equipment to support care and treatment delivery. The wards had a good standard of environment and provision with quiet spaces to use, therapy rooms, sensory rooms, large en suite bedrooms, personalised where requested and visitor rooms all attractively and creatively furnished. The design and standard of the newly refurbished wards were excellent.
- Patients had access to very well resourced occupational therapy areas. Patients were encouraged to leave the ward areas during the day to attend the occupational therapy facilities with staff.
- Staff told us that patients could request a cordless office phone to use in one of the quiet rooms if they wanted to make a private phone call.
- Each ward had access to large outside gardens, all within the perimeter fence. We looked at an area called the wildlife garden, which was accessible to all wards within the perimeter fence. This area had been planted attractively and we saw that a variety of horticultural endeavour was underway, led by both clinical staff and patients. We saw a permanent gazebo/ summerhouse there, with a café. On the day of our inspection, an external entertainer was singing for and with patients. All patients were able to enjoy the outside facilities, many with staff supervision, as the perimeter secure fence was on the outside of all available space.
- All of the patients we spoke to commented positively about the quality and variety of food served. We were told that if patients had specific dietary requirements or preferences that a chef would visit the ward to speak directly with the patient. The chef held regular meetings with patients to hear feedback about the food provided and encouraged suggestions for improvements.
- There were no facilities available on any of the wards for patients to make cold or hot drinks or to have snacks throughout the night and day. Patients could ask for drinks, which staff would make, and staff offered drinks and snacks to patients at regular intervals during the day. When we asked a variety of staff about this blanket restriction, we received mixed views. Some staff commented on the level of risk which would be introduced if patients had access to hot water, other

staff viewed the restriction as patronising, de-skilling and institutional. This approach was not in keeping with an individualised and enabling culture we saw in other areas of the service provided. We discussed this with the hospital managers who agreed to review this restriction.

- Patients were encouraged to personalise their bedrooms and the communal areas of the wards. Patients showed us around some bedrooms and we could see that they had created a homely environment, if they wanted to. All of the wards and the communal areas throughout St Magnus had enhanced the environment with the use of soft furnishings and pictures to an exceptionally high standard. Some areas, for example the visiting rooms, reception areas and sensory rooms were quite remarkable and striking in their design and degree of comfort afforded.
- All patients, if they could do so, had an electronic wrist fob to gain access to and lock their bedrooms and could gain access at any time. Patients were all able to store their possessions securely.
- Daily and weekly activities were advertised and available on and off all wards. An excellent range of activities and groups was available to patients on all of the wards, facilitated by the activity co-ordinators and ward staff. The activities were varied, recovery focused and aimed to motivate patients. Patients were actively encouraged to make suggestions for activities they would like. Sessions were available on a wide variety of skills based learning and included emotional literacy, balance improvement, falls prevention, social skills training, fun activities and creative groups. During our inspection, we joined a number of these activities and found them inclusive, creative and enjoyable.
- We saw examples of activities undertaken by patients and we discussed these with them. Examples included; watching films, healthy eating, current affairs, walks around the hospital and local area, gardening projects, computer courses, cookery classes, relaxation, music appreciation, art and poetry and much more. Many activities involved ward staff and we found all staff motivated and driven to embrace the recovery based approach. We were particularly pleased to join patients at a visiting petting zoo session. We saw that patients were able to connect positively with staff while watching and touching some of the animals. We saw one patient smiling and stimulated by the animals. The patient had appeared uninterested and withdrawn on the ward earlier in the day.
- Occupational therapy was available across all wards and a variety of therapy sessions was available on all wards. We saw they operated a model, which focused on a holistic, person-centred and recovery-based approach.
- A dedicated gym instructor provided group and individual activities. We saw the well-equipped gym and heard that patients all received an induction and personalised plan. Only one staff member had the necessary training to use the gym. Patients could therefore only use the gym when that staff member was on duty and not at any other time, for example evenings or weekend periods.

Meeting the needs of all people who use the service

- All of the wards had full disability access.
- Staff respected patients' diversity and human rights, and asked about people's cultural, language and religious needs at admission. Contact details for local faith representatives were available. Patients used the sensory rooms in both the low secure and locked recovery areas as multi faith areas. We discussed the facilities with staff and noted that there were no holy books or prayer mats available for use. Staff said that if a patient required these, then they could have them, but we saw no reason why the items could not have been stored in one of the available cupboards in the rooms, which otherwise had a high standard of furnishing.
- Interpreters were available and used, when required. Leaflets were available explaining patients' rights under the Mental Health Act.
- There was up to date and relevant information on the wards and in communal areas which included information for visitors, contact details and information on advocacy, information on mental health problems and available treatment options, local services for example on benefits advice and how to raise a concern or make a complaint.
- All wards had an extensive variety of books, games, puzzles, CDs and DVDs, all on show and available to patients at any time.

Long stay/rehabilitation mental health wards for working age adults

- A choice of meals was available. A varied menu enabled patients with particular dietary needs connected to their religion or culture, and others with particular individual needs or preferences, to eat appropriate meals. A chef was readily available to speak to any patient with specific dietary requests or preferences.

Listening to and learning from concerns and complaints

- There were 24 formal complaints in the 12 months preceding the inspection for the whole of St Magnus Hospital. The provider upheld eleven of these, which showed us that the provider was fair and transparent when dealing with complaints.
- Copies of the complaints process were on display in all of the wards and in the ward information handbooks. Patients and their relatives we spoke with all knew how to make a complaint should they wish to do so.
- Staff confidently described the complaints process and how they would handle any complaints. Staff told us that they try to deal informally with concerns and to do this promptly in an attempt to provide a timely resolution to concerns.
- Senior staff met regularly with the clinical governance team to discuss learning from complaints. This informed a programme of improvements and training, for example labelling patients' property clearly to avoid misplacing items and briefing sessions for staff on duty of candour.

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

Good

Vision and values

- The provider's vision, values and strategies for the service were evident and on display in all of the wards. Staff on the wards understood the vision and direction of the organisation. Staff at every level felt very much a part of the service and were able to discuss the philosophy of the hospital confidently.
- The ward managers had regular contact with the hospital manager, medical director and the hospital director. The senior management and clinical team were highly visible and staff said that they regularly visited the ward, usually every day.
- Good administrative support was provided from the clinical governance team and the ancillary services such as housekeeping, catering, transport, human resources, the education centre, administration and maintenance departments.
- We heard excellent feedback about the senior clinical leads and the director responsible for St Magnus. Staff said that the senior management team had great experience and they could ask them about any matter at any time. Staff were confident the response would be proactive and responsive.

Good governance

- The wards had access to systems that enabled staff to monitor and manage the wards effectively, and provided information such as incident reporting, management of complaints, and human resource information about staff and their training to senior staff in a timely manner. However, we noted that there was little formal information on controls either expected or produced. Managers told us that as the services are on one site and given that the business and clinical governance teams were readily available, that this was sufficient mitigation. We noted however that there was no risk register available either singularly for each ward or severally for the hospital. Ward managers could talk about the risks but there was no single system for listing or reporting them. We saw no performance dashboards or key performance indicator framework available for the ward managers or their wards. This meant there was a chance of under- reporting and underperformance, which could have gone unchecked. We raised this with senior managers as we determined that there was no formal method of managing expected performance or dealing effectively with any underperformance.
- We noted that the ward managers did not manage any aspect of the ward budgets. The ward managers told us that the hospital manager and director controlled all financial management processes. Managers told us that all requests, within reason, for additional resources were met positively by their senior managers. Senior

managers also told us that they did not ask ward managers to carry out this task to avoid reducing the time they had available for patients and staff on the wards.

- All ward managers told us that they were encouraged by their managers to work autonomously in managing their wards and received excellent support from the hospital manager, medical director and the service director.

Leadership, morale and staff engagement

- Ward managers were in post and led the wards well. The ward managers were visible on the wards during the day-to-day provision of care and treatment, they were accessible to staff and they were proactive in providing support. Staff told us that the culture on the wards was open and encouraged them to bring forward ideas for improving care, which we sampled.
- All of the ward staff we spoke to were enthusiastic and engaged with developments on the wards. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident their line managers would listen to them. Some staff gave us examples of when they had spoken out with concerns about the care of people and said managers received this positively as a constructive challenge to ward practice.
- Staff told us that staff morale was "very good" and observations throughout our inspection confirmed this.
- All wards took time out to attend multi-disciplinary away days.
- Sickness and absence rates were very low at 1.2%.
- Staff were aware of the whistleblowing process if they needed to use it.

Commitment to quality improvement and innovation

- Accredited members of the Royal College of Psychiatrists quality network for low secure mental health services. (March 2015)
- Staff participated in wide range of clinical audits to monitor the effectiveness of services provided. We saw that all staff participated, at least weekly, in reflective practice sessions to evaluate the effectiveness of their interventions. Audits included reviewing adherence to annual physical health checks for patients, reviewing adherence to the CPA policy and associated risk assessments, crisis and contingency planning, ensuring good practice in prescribing and management of medication, adherence to the Mental Health Act Code of Practice and evaluating the effectiveness of a variety of health and safety practices and protocols.

Outstanding practice and areas for improvement

Outstanding practice

- Physical health care assessments were co-ordinated and thorough for all patients. All of the wards adhered to the Department of Health (2010) requirements that venous thromboembolism (VTE) risk assessments take place for every patient. We saw that the practice adhered to the NICE (2010) recommendations on VTE risk assessments. Staff assessed patients with the malnutrition Universal Screening Tool (MUST) and they developed associated care plans where appropriate. This ensured patients were not at risk of malnutrition.
- The provider used the NHS safety thermometer, which provided a method for surveying patient risks and harms. This enabled the provider to analyse results and monitor patient safety data in order to provide care free from harm. For example, the improvement tool recorded all potential occurrences of pressure ulcers, infections and falls.
- Staff participated in a wide range of clinical audits to monitor the effectiveness of services provided. We saw that all staff participated, at least weekly, in reflective practice sessions to evaluate the effectiveness of their interventions. Audits included reviewing adherence to annual physical health checks for patients, reviewing adherence to the care programme approach (CPA) policy and associated risk assessments, crisis and contingency planning, ensuring good practice in prescribing and management of medication, adherence to the Mental Health Act Code of Practice, and evaluating the effectiveness of a variety of health and safety practices and protocols.
- The training and professional development opportunities offered to all staff were exemplary. Staff told us without exception that their training and development needs were always supported and delivered. For example all support staff were encouraged to apply for the certificate in care training. All nurses were encouraged to train in both mental health and general nursing to obtain dual qualifications.
- At Park House a guest room was available for family members to stay overnight if they needed to be with their relative. A flexible approach to the length of time relatives could stay in the room meant those with a family member receiving end-of-life care could spend more time at the hospital.

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should install bedroom door viewing panels to all rooms in all wards, because, currently, bedroom doors have to be opened for day and night observation checks on patients, which could disturb their sleep.
- The provider should review the blanket restriction on patients making their own hot or cold drinks. This means any restrictions should be on the basis of individually assessed risk rather than applying restrictions to all patients regardless of risk.
- The provider should consider training additional staff to facilitate use of the gym as staff told us that only one staff member was currently trained, which meant the gym was only used when this staff member was on duty and not at any other time, for example evenings or weekends.
- The provider should consider having a dedicated multifaith room and having holy books and a prayer mat available in the room.
- The provider should review formal governance information processes including key performance indicators and risk registers for the wards. This means that the outcomes of performance and key risks are written up and available for staff to see.

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.

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.