Cygnet Health Care Limited

Cygnet Hospital Bierley

Inspection report

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Date of inspection visit: 31 January 2022 to 2nd February 2022 and 8th February 2022
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Overall summary

Our rating of this location went down. We rated it as inadequate because:

- The service did not reduce or remove all risks identified on the wards and staff could not always observe patients in all parts of the wards.
- The service did not have enough nursing staff, who knew the patients and received basic information to keep people safe from avoidable harm.
- Staff did not always identify and respond to any changes in risks to, or posed, by patients. Staff did not participate in a restrictive intervention's reduction programme, which met best practice standards.
- The service did not always have access to the full range of specialists required to meet the needs of patients on the wards. On Bronte ward they did not always support staff with appraisals and supervision.
- Staff did not always treat patients with compassion and kindness. They did not always respect patients' privacy and dignity. They did not always understand the individual needs of patients and did not always support patients to understand and manage their care, treatment, or condition.
- Leaders did not always have the skills, knowledge, and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service and approachable for patients and staff.
- Some staff did not feel respected, supported, and valued. They could not raise concerns without fear of retribution.
- On Bowling ward, staff did not consistently follow systems and processes to safely prescribe, administer, record and store medicines.
- On Denholme ward, some staff did not always have easy access to clinical information.
- The service did not manage patient safety incidents well. Staff did not recognise incidents and report them appropriately. Managers did not always investigate incidents and share with the appropriate organisations.

Letter from the Chief Inspector of Hospitals

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

Chief Inspector of Hospitals

A final version of this report, which we will publish in due course, will include full information about our regulatory response to the concerns we have described.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Personality disorder services	Inadequate 	Our rating of this service went down. We rated it as inadequate because: • The service did not reduce or remove all risks identified on the ward and staff could not always observe patients in all parts of the ward. • The service did not have nursing enough staff who knew the patients and received basic information to keep people safe from avoidable harm. • Staff did not assess and manage risks to patients and themselves well and staff did not participate in a provider's restrictive interventions reduction programme, which met best practice standards. • Staff did not consistently follow systems and processes to safely prescribe, administer, record and store medicines. • Staff did not always treat patients with compassion and kindness. They did not always respect patients' privacy and dignity. They did not always understand the individual needs of patients and support patients to understand and manage their care, treatment, or condition. • Leaders did not always have the skills, knowledge, and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service and approachable for patients and staff. • Some staff did not feel respected, supported, and valued. They could not raise concerns without fear of retribution.
Forensic inpatient or secure wards	Inadequate 	Our rating of this service went down. We rated it as inadequate because: • The service did not have enough nursing staff, who knew the patients and received basic information to keep people safe from avoidable harm. • Staff did not always identify and respond to changes in risks to, or posed, by patients. Staff did not participate in a restrictive intervention's reduction programme, which met best practice standards.

Summary of findings

- The service did not always have access to the full range of specialists required to meet the needs of patients on the wards. They did not always support staff with appraisals and supervision.
- Staff did not always treat patients with compassion and kindness. They did not always respect patients' privacy and dignity. They did not always understand the individual needs of patients and did not always support patients to understand and manage their care, treatment, or condition.
- Leaders did not always have the skills, knowledge, and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service or approachable for patients and staff.
- Some staff did not feel respected, supported, and valued. They could not raise concerns without fear of retribution.

However:

- The ward environments were safe, well equipped, well furnished, well maintained and fit for purpose.
- The service used systems and processes to safely prescribe, administer, record and store medicines.

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

Inadequate

Our rating of this service went down. We rated it as inadequate because:

- The service did not reduce or remove all risks identified on the ward. Staff could not always observe patients in all parts of the wards and staff did not always mitigate the risks to keep patients safe.
- The service did not have enough nursing staff, who knew the patients and received basic information to keep people safe from avoidable harm.
- Staff did not always assess and manage risks to patients and themselves well. Staff did not participate in a restrictive intervention's reduction programme.
- Some staff did not always have easy access to clinical information.
- The service did not manage patient safety incidents well. Staff did not recognise incidents and report them appropriately. Managers did not always investigate incidents and share with the appropriate organisations.

Summary of findings

- The ward team did not always have access to the full range of specialists required to meet the needs of patients on the ward. Managers did not always provide an induction programme for new staff.
- Staff did not always explain to each patient their rights under the Mental Health Act in a way that they could understand, and staff did not always make sure patients could take section 17 leave.
- Staff did not always involve patients in care planning and risk assessment or actively seek their feedback on the quality of care provided. They did not always ensure that patients had easy access to independent advocates.
- Leaders did not always have the skills, knowledge, and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service and approachable for patients and staff.
- Some staff did not feel respected, supported, and valued. They could not raise concerns without fear of retribution.

However:

- The service had systems and processes in place to safely prescribe, administer and record and store medicines use. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Summary of findings

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Summary of this inspection

Background to Cygnet Hospital Bierley

Cygnet Hospital Bierley is an independent mental health hospital provided by Cygnet Health Care Ltd situated in West Yorkshire.

The hospital is registered to provide care for up to 56 male and female patients across four different inpatient wards:

- Bronte ward is a 12-bed forensic low secure service for women
- Shelley ward is a 16-bed forensic low secure service for men
- Denholme ward is a 12-bed psychiatric intensive care unit for women
- Bowling ward is a 16-bed specialist personality disorder service for women

The hospital has been registered with the Care Quality Commission since October 2010 to carry out the following regulated activities:

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

The hospital had a registered manager and an accountable controlled drugs officer.

The Care Quality Commission last carried out a comprehensive inspection of this hospital in May 2021. As a result of that inspection, we rated the service as 'Requires Improvement' overall. The forensic services were rated requires improvement overall with safe, effective, caring and well led domains requiring improvement. The psychiatric intensive care unit was rated good overall, with safe requiring improvement. The personality disorder service was last inspected in August 2020 as part of a focused inspection in response to concerns raised about the safety and culture of the service. The service was rated as requires improvement overall with the safe and well led domains requiring improvement. The hospital was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at the last inspection:

- Regulation 12 Safe care and treatment
- Regulation 13 Safeguarding
- Regulation 17 Governance

As a result of concerns received about the safety and culture of the service the Care Quality Commission carried out a responsive focused inspection. This inspection focussed on specific areas of concern, which meant that we did not inspect all the key questions. We focused our inspection on the following areas:

- Safe
- Caring
- Well Led

Due to concerns we found whilst on site, we also looked at questions under the Effective domain.

What people who use the service say

Summary of this inspection

We spoke with relatives or carers of four patients on the female low secure forensic ward and the personality disorder ward. We were provided with contact numbers for two relatives and carers of the patients on the psychiatric intensive care unit, but they were not available. We had asked the service to ensure carers and relatives were informed that an expert by experience would be calling for their feedback, but the service had only gained patient consent and some of the carers and relatives we spoke to were unaware of our call.

The carers we did speak to said that agency staff are less understanding and helpful and that the weekend is mainly staffed by agency workers. They said communication was a real struggle with the service as they do not always answer the phone or return phone calls. They also said there were issues around ensuring carers were informed about changes in leave arrangements or medication.

We spoke to 15 patients using the service.

Three out of the four patients we spoke to on the male low secure forensic ward told us that there were not enough activities and that they are required to open mail in front of staff. One patient said that some staff speak to them badly.

Two out of the three patients we spoke to on the female low secure forensic ward told us that there was not a lot of activities and that the ward was very noisy. One patient told us that they are sometimes required to open mail in front of staff, but it depended on which staff member was in. One patient told us there was not enough staff.

All four patients we spoke to on the personality disorder ward said there were not enough activities and that there is a large number of agency staff who do not know the ward, or the patients and they do not feel safe when agency staff are on shift. One patient told us that one agency staff member called the patients by their room number. They said that they do not get a debrief if they have witnessed an incident on the ward. Three patients said that the current practices could be fatal.

Two of the four patients we spoke to on the psychiatric intensive care unit told us that the ward was not clean. All four patients said they did not feel safe on the ward due to other patients attempting to physically assault them.

How we carried out this inspection

The team that inspected the service comprised of two CQC inspectors, two specialist pharmacy CQC inspectors, a Mental Health Act reviewer, one expert by experience and two mental health nurse specialist advisors.

During the inspection, the inspection team:

- visited three wards
- spoke to 15 patients who were using the service
- spoke with the registered manager, clinical manager, and the head of social work
- spoke with four ward managers
- spoke with four carers/relatives
- spoke with 23 staff members including nurses, support workers, housekeepers, human resources and freedom to speak up guardian
- spoke with 15 external agencies
- looked at 12 care and treatment records for patients
- attended meetings specific to patient care and the running of the service

Summary of this inspection

- looked at a range of policies, procedures, and other documents relating to the running of the service.

Visits were unannounced and took place on the evening of 31 January 2022 and during the day on 1 February 2022, 2 February 2022 and 8 February 2022.

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

Areas for improvement

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

Action the service MUST take to improve:

Personality Disorder Services

- The provider must ensure that patients receive safe care and treatment and prevent avoidable harm or risk of harm. The provider must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills, and experience to keep people safe. (Regulation 12)
- The provider must ensure they review the contraband list for the hospital and the three separate core services and ensure these lists are clear and appropriate and do not contradict each other. (Regulation 12)
- The provider must ensure that all staff have received training to complete service user observations. Including seclusion observation. (Regulation 12)
- The provider must ensure that all staff are up to date on their mandatory training. (Regulation 12)
- The provider must ensure that they introduce and follow a restrictive interventions reduction programme that follows best practice guidance. (Regulation 12)
- The provider must ensure that clear and accurate records of medicines administration are maintained, and when indicated, that the appropriate mental health act authorities are in place. (Regulation 12)
- The provider must ensure the current permanent staffing levels on the wards match the needs of the service and work to reduce the amount of agency staff used. (Regulation 18)
- The provider must ensure that there are enough staff available seven days a week to be able to offer patients varied range of activities. (Regulation 18)
- The provider must ensure that effective handovers are completed and documented and that all staff are able to access patient information quickly and efficiently. (Regulation 18)
- The service much ensure that they review the negative culture and chaotic nature of the wards so that they are able to assess, monitor and mitigate risks relating to the health, safety and welfare of patients and staff. (Regulation 17)
- The provider must ensure there are robust governance arrangements in place for the allocation and induction of agency staff at the service. (Regulation 17)
- The service must review their management systems so that there are effective structures in place to monitor and mitigate any risks relating the health, safety and welfare of patients and staff. (Regulation 17)
- The service must ensure that effective governance processes are implemented and followed to ensure safe care and treatment of patients. (Regulation 17)
- The service must conduct meaningful exit interviews with all staff who leave the service. (Regulation 17)

Summary of this inspection

- The service must ensure that people using the service receive consistent and appropriate person-centred care and treatment that is based on an assessment of their needs and preferences and are responsive to requests for information to ensure the continued progression of a person's treatment. (Regulation 9)
- The service must ensure that patients on the personality disorder ward are individually assessed for the most appropriate therapy and restrictions are based on an individual risk assessment. (Regulation 10)
- The service must ensure that people using the service are treated with respect and dignity at all times whilst they are receiving care and treatment. (Regulation 10)
- The provider must ensure that when patients are not detained under the Mental Health Act, that informed consent is gained from the informal patient and the legal rights of an informal patient are adhered to. (Regulation 13)

Forensic inpatient or secure wards

- The provider must ensure that patients receive safe care and treatment and prevent avoidable harm or risk of harm. The provider must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills, and experience to keep people safe. (Regulation 12)
- The provider must ensure they review the contraband list for the hospital and the three separate core services and ensure these lists are clear and appropriate and do not contradict each other. (Regulation 12)
- The provider must ensure that all staff have received training to complete service user observations. Including seclusion observation. (Regulation 12)
- The provider must ensure that all staff are up to date on their mandatory training. (Regulation 12)
- The provider must ensure that they introduce and follow a restrictive interventions reduction programme that follows best practice guidance. (Regulation 12)
- The provider must ensure the current permanent staffing levels on the wards match the needs of the service and work to reduce the amount of agency staff used. (Regulation 18)
- The provider must ensure that there are enough staff available seven days a week to be able to offer patients varied range of activities. (Regulation 18)
- The provider must ensure that effective handovers are completed and documented and that all staff are able to access patient information quickly and efficiently. (Regulation 18)
- The provider must ensure that all staff get appropriate supervision and appraisal. (Regulation 18)
- The service much ensure that they review the negative culture and chaotic nature of the wards so that they are able to assess, monitor and mitigate risks relating to the health, safety and welfare of patients and staff. (Regulation 17)
- The provider must ensure there are robust governance arrangements in place for the allocation and induction of agency staff at the service. (Regulation 17)
- The service must review their management systems so that there are effective structures in place to monitor and mitigate any risks relating the health, safety and welfare of patients and staff. (Regulation 17
- The service must ensure that effective governance processes are implemented and followed to ensure safe care and treatment of patients. (Regulation 17)
- The service must conduct meaningful exit interviews with all staff who leave the service. (Regulation 17)
- The service must ensure that people using the service receive consistent and appropriate person-centred care and treatment that is based on an assessment of their needs and preferences and are responsive to requests for information to ensure the continued progression of a person's treatment. (Regulation 9)
- The service must ensure that people using the service are treated with respect and dignity at all times whilst they are receiving care and treatment. (Regulation 10)

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

- The provider must ensure that patients receive safe care and treatment and prevent avoidable harm or risk of harm. The provider must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills, and experience to keep people safe. (Regulation 12)

Summary of this inspection

- The provider must ensure they review the contraband list for the hospital and the three separate core services and ensure these lists are clear and appropriate and do not contradict each other. (Regulation 12)
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- The service must ensure that effective governance processes are implemented and followed to ensure safe care and treatment of patients. (Regulation 17)
- The service must conduct meaningful exit interviews with all staff who leave the service. (Regulation 17)

Action the service SHOULD take to improve:

Personality Disorder Services

- The provider should continue their recruitment of housekeepers to ensure there are enough staff to complete all the required cleaning tasks across the hospital
- The provider should continue to ensure that care records are easily accessed and navigated for all staff working on the ward.
- The provider should continue to ensure that when patients are required to open mail in front of staff that this is individually risk assessed and the relevant decision documented and regularly reviewed.
- The service should ensure they continue the planned upgrades of the windows across the hospital site to ensure the safe care and treatment of patients and to ensure patient's privacy on a night-time.
- The service should ensure that all staff and patients are provided with an appropriate debrief following incidents.
- The service should ensure that they liaise and involve relevant persons in decisions relating to a patient's care or treatment where appropriate.
- The provider should ensure that all patients are made aware of their rights when admitted to the ward and continue to explain their rights as per the Mental Health Act code of practice.
- The provider should ensure that care plans for violence or aggression are kept up to date to reflect any changes in patients' prescriptions.
- The provider should ensure all clinical staff have completed an introduction to dialectical behaviour therapy (DBT)

Forensic inpatient or secure wards

- The provider should continue their recruitment of housekeepers to ensure there are enough staff to complete all the required cleaning tasks across the hospital

Summary of this inspection

- The provider should continue to ensure that when patients are required to open mail in front of staff that this is individually risk assessed and the relevant decision documented and regularly reviewed.
- The service should ensure they continue the planned upgrades of the windows across the hospital site to ensure the safe care and treatment of patients and to ensure patient's privacy on a night-time.
- The service should ensure that they liaise and involve relevant persons in decisions relating to a patient's care or treatment where appropriate.
- The provider should ensure that all patients are made aware of their rights when admitted to the ward and continue to explain their rights as per the Mental Health Act code of practice.
- The provider should continue to re-visit rapid tranquilisation post dose monitoring requirements with staff to ensure they are understood on wards where it is infrequently used.
- The provider should ensure that medicines clinical audit outcomes are reviewed and where appropriate action plans are put in place to support continuous improvement.

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

- The provider should continue their recruitment of housekeepers to ensure there are enough staff to complete all the required cleaning tasks across the hospital.
- The provider should continue to ensure that when patients are required to open mail in front of staff that this is individually risk assessed and the relevant decision documented and regularly reviewed.
- The service should ensure they continue the planned upgrades of the windows across the hospital site to ensure the safe care and treatment of patients and to ensure patient's privacy on a night-time.
- The provider should ensure that all patients are made aware of their rights when admitted to the ward and continue to explain their rights as per the Mental Health Act code of practice.
- The provider should ensure that medicines safety alerts are promptly acknowledged to ensure that any identified actions are promptly addressed.
- The provider should ensure that care plans for violence or aggression are kept up to date to reflect any changes in patients' prescriptions.
- They provider should ensure that patients have easy access to independent advocates.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Personality disorder services	Inadequate	Requires Improvement	Requires Improvement	Not inspected	Inadequate	Inadequate
Forensic inpatient or secure wards	Inadequate	Requires Improvement	Requires Improvement	Not inspected	Inadequate	Inadequate
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires Improvement	Requires Improvement	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Insufficient evidence to rate	Inadequate	Inadequate

Inadequate

Personality disorder services

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Well-led	Inadequate

Are Personality disorder services safe?

Inadequate

Safe and clean care environments

The service did not reduce or remove all risks identified on the ward and staff could not always observe patients in all parts of the ward.

Safety of the ward layout

The service did not reduce or remove all risks identified on the ward. Although staff completed and regularly updated thorough ligature risk assessments which identified fixed ligature points the service had plastic bags on the ward which were on the hospital contraband list and a patient was able to access a known risk item six separate times from October 2021 to February 2022 despite the hospital putting mitigation in place.

Staff could not always observe patients in all parts of the wards and staff did not always mitigate the risks to keep patients safe. The service did have mirrors for blind spots, but some rooms were not covered by these. There were patients on the ward who were a risk of self-harm.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness, and infection control

The ward area was clean and tidy and well furnished.

Staff did not always make sure cleaning records were up to date. In January 2022 we found six days where not all cleaning tasks were marked as completed for non-patient areas. There was one night in January 2022 where the cleaning checklist was missing. Six housekeeping weekend recording sheets and four housekeeping daily record sheets on Bowling ward in January 2022 stated the housekeeping team were short staffed.

The anti-barricade had been broken on the quiet room door since November 2021 and was listed on the anti-barricade checker four times from November 2021 until January 2022. The registered manager was not aware of this until we raised it and they advised this should have come through to the morning communication meeting which it had not. We were advised that the anti-barricade checker should be completed weekly, but from November 2021 until January 2022 there had only been five checks completed.

We received a complaint from a patient on the ward that the windows on the ward offered no privacy at night-time and the ward windows lacking privacy was listed on the 19 January 2022 morning communication meeting minutes. The

service advised us that fluorescent lights used by some of the patients meant the privacy screening that was applied to all windows did not work and the patients could close their curtains if needed. The schedule of works for the service did not include having this rectified and although the service had told us it would be included in the schedule of works, they did not respond when we asked when they expected it to be completed. Following the inspection period, the service began works to replace all external windows.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. Staff stored and managed all medicines and prescribing documents safely. The clinic room was clean, orderly, and secure. Checks of the room and fridge temperature were carried out and recorded to ensure that medicines were stored at the right temperatures.

Safe staffing

The service did not have enough staff, who knew the patients and received basic information to keep people safe from avoidable harm.

Nursing staff

The ward did not have enough nursing and support staff to keep patients safe. We reviewed two weeks of rotas from the week commencing 17 January 2022 until 30 January 2022. The ward required two nurses for each shift. There were two shifts that only had one nurse present. There were six shifts that were staffed solely by agency nurses and on 23 January 2022 there was only one nurse on shift who was an agency staff nurse. Agency nurses worked 11 shifts in total with seven of those nurses being non-regular agency workers.

The service had high vacancy rates. There were 5.3 vacancies for nurses and six vacancies for support workers on Bowling ward.

The service had high rates of bank and agency nurses and support workers. From January 2021 to January 2022 the personality disorder ward had used agency staff for 2,587.1 shifts and bank staff for 292 shifts.

Managers did not limit their use of bank and agency staff and did not always request staff familiar with the service. Two carers of patients we spoke to said agency staff were less understanding and helpful. Two staff members and two patients on Bowling ward, said the patients have more incidents due to the high amount of agency staff on a night who do not know the patients triggers. Patients said they were not always able to access their toiletries on a night due to agency staff not having access to the security keys where patients' toiletries are kept. The Bowling ward community meeting minutes for January 2022 stated that a patient had fed back that agency staff did not know what they are doing and in the community meeting minutes for November 2021 that patients would not mind agency staff if they just spoke to us.

Managers did not make sure all bank and agency staff had a full induction and understood the service before starting their shift. We requested induction checklists for five agency staff who had worked on the ward in the previous two weeks of our inspection. We were provided with two security induction checklists and no induction checklists. The hospital had listed use of agency on their risk register stating, "staff unfamiliar with the wards, patients and procedures could pose a risk to the safety and quality of care in the Hospital. We are averaging 40% usage."

The service had high turnover rates. Across all three core services there was a turnover rate of 52% for the previous 12 months. From August 2021 to January 2022, 49 members of staff had left the hospital. This was higher than our previous report in May 2021 of 31%. Bowling ward had an average turnover rate from November 2021 to January 2022 of 4%.

Managers supported staff who needed time off for ill health. Bowling ward had an average sickness rate of 5% from November 2021 to January 2022. The hospital had an average sickness rate of 7% for all three core services for the previous 12 months which is higher than our previous report in May 2021 of 5%.

Managers did not always accurately calculate and review the number and grade of nurses and support workers for each shift. The managers at the service had a weekly rota meeting to review the staffing across the hospital. During our observation of this meeting, it was found that a nurse agency staff member had been allocated to work on Bowling ward and another ward at the hospital that night and on the previous night.

The ward manager could adjust staffing levels according to the needs of the patients. Observation levels of patients were taken into account when deciding staff numbers. After our inspection the service implemented a daily review of staffing in the service. It was found that on Bowling ward from 4 February 2022 until 20 February 2022 they were short the required number of support workers on five night shifts and one day shift.

Patients had regular one-to-one sessions with their named nurse.

Patients sometimes had their escorted leave or activities cancelled when the service was short staffed. Two carers told us that scheduled home leave was sometimes cancelled which caused distress for the patients and for their families. The patients had to attend a morning meeting from Monday to Friday to prioritise leave requests. Requests outside of this meeting during the week and on a weekend were dealt with on an ad hoc basis.

Staff did not always share key information to keep patients safe when handing over their care to others. In Bowling wards December 2021 team meeting minutes, they noted that security and self-harm related incidents could have been avoided had staff been fully made aware of the risks. Two patients and one staff member on Bowling said that some staff did not know the ward very well. A patient on the ward had been able to self-harm multiple times with the same item despite mitigation being put in place. We asked the ward if there was any documentation provided to staff which quickly and adequately highlighted risks to patients and we were told the daily verbal handover provided this. Although the service had implemented a handover document that highlighted one patients' specific triggers, this had not mitigated against further incidents.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Inadequate

Personality disorder services

Mandatory training

Staff had not completed and kept up to date with their mandatory training. The three staff who required electrocardiogram (ECG) training were not up to date on their training. 69% of staff were up to date on their emergency first aid at work including basic life support with an automated external defibrillator training and 67% of staff had received their fire warden training. 71% of staff were up to date on the personality disorder e-learning and 60% had received the risk assessment training.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. They did not achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. However, not all staff were up to date on the risk assessment training.

Management of patient risk

Staff did not always know about risks to each patient and did not always act to prevent or reduce risks. A patient was able to ligature on a known risk item six separate times from October 2021 to February 2022 whilst being observed by staff prior to, during and after our inspection. The Bowling ward staff meeting minutes from December 2021 states "There have been security and self-harm related incidents that could have been avoided if staff were fully made aware of these risks before undertaking enhanced observations."

The provider had a hospital wide contraband items list. However, this was not ward specific and was not reviewed regularly and updated depending on the patient group. The ward did have a blanket rules audit and regular meeting but not all of the items listed on the hospital wide contraband listed were reviewed.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The provider had an up-to-date policy that was followed, and body searches were only completed with agreement from the responsible clinician.

Use of restrictive interventions

The ward had used restraint on patients 75 times from November 2021 until January 2022.

Staff did not participate in a restrictive intervention's reduction programme, which met best practice standards. We requested information about the provider's restrictive interventions programme and were provided with the wards blanket rule audit and meeting minutes. We did request this information for a second time to ensure restraint, seclusion and rapid tranquilisation were not included and were advised again that the programme was in relation only to blanket rules.

Staff followed NICE guidance when using rapid tranquilisation. The ward had used rapid tranquilisation 31 times from November 2021 until January 2022.

Safeguarding

The safeguarding team understood how to protect patients from abuse and worked well with other agencies to do so. Staff had training on how to recognise and report abuse.

Staff received and kept up to date with their safeguarding training on how to recognise and report abuse, appropriate for their role. All staff were up to date on the intermediate safeguarding adults at risk training.

The safeguarding team at the service knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Children were able to visit patients in the hospital visiting room off the ward. Whenever a child is due to visit the service, the safeguarding team have a process in place to ensure there is no known risk and all interested third parties agree to the visit. We observed the safeguarding team liaising with police and safeguarding services to ensure the safety of the children of a patient.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers did not take part in serious case reviews.

Staff access to essential information

Staff did not always have easy access to clinical information.

Patient notes were comprehensive but not all staff could access them easily. The service used a combination of electronic and paper records and records were stored securely. Whilst on site we were unable to review the online risk assessments for one patient due to system issues and were also unable to find a Mental Health Act T3 (no consent to psychiatric medication) form for one patient in the paper records.

Medicines management

Staff did not consistently follow systems and processes to prescribe and administer medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff did not consistently follow systems and processes to prescribe and administer medicines safely. The dose given for one medicine was not recorded for the administration of a variable dose medicine and a duplicate record for the administration of a depot injection had not been updated to reflect a change in dose. One patient had not received their new medicine for seven days as there was none in stock.

Individual care plans were in place for people where there was a risk of violence or aggression. These plans included information about the use of any prescribed 'when required' medicines. However, one care plan had not been kept up to date with changes to the patient's prescription.

Patients were supported to self-administer medicines where possible, this was kept under review to help ensure medicines were handled safely. However, we found that on occasion staff did not make checks of safe self-administration as often as stated within people's plans.

Staff reviewed the effects of medicines on patients' physical health and a self-reporting tool was used to monitor for potential side effects of antipsychotic medicines. Physical health monitoring following rapid tranquilisation (medicine given to manage aggression or agitation) was generally completed in accordance with hospital policy with 93% compliance in the hospitals audit for December 2021.

Patients' medicines and physical heath was reviewed as part of the monthly ward round. However, staff did not always provide advice to patients and carers about their medicines. One carer told us that when the patient is on home leave that no medication information is provided.

Inadequate

Personality disorder services

An audit by the hospital's visiting pharmacist from October 2021 to December 2021, found ten mental health act errors when reviewing patients' prescription charts and associated authorities. We similarly found two medicines related mental health act errors in the six records we examined. We raised these concerns with the doctor in order that they could be promptly addressed.

Medicines audit and incidents were shared at the hospital clinical governance meeting and cascaded for action and learning by ward managers at ward staff meetings. However, only limited information was shared from clinical audits completed by the pharmacist. For example, the hospital did not have an action plan in response to an antibiotic audit which was completed in November 2021.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers did not always investigate incidents and share lessons learned with the whole team and the wider service.

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

Staff reported serious incidents clearly and in line with provider policy.

The service had no never events on any wards.

Managers did not always debrief and support staff after all serious incidents. Two staff members out of the four we spoke to told us that they did not always receive a debrief following incidents of restraint. The Bowling ward staff meeting minutes in January 2022 state that staff debriefs, and reflection had stopped happening due to the ward being so busy. However, the hospital had a wobble room where staff could go if they needed time out.

Managers did not always investigate incidents thoroughly. Despite our requests, we have not received the investigation report from five incidents between October 2021 and February 2022 on Bowling ward. Three are in relation to a patient on the ward who was able to self-harm with the same item despite mitigation being put in place after the initial incident with one outstanding investigation report from October 2021 and two outstanding investigation reports from February 2022.

Are Personality disorder services effective?

Requires Improvement

Skilled staff to deliver care

The ward team did not always have access to a consistent range of specialists required to meet the needs of patients on the ward. Managers did not always make sure they had staff with the range of skills needed to provide high quality care.

The service did not always ensure that patients had access to a consistent range of specialists to meet the needs of the patients on the ward. There had been eight responsible clinicians on the ward from January 2021 until February 2022.

During our review of the communication meeting minutes we saw that there was a range of between two to four people off sick daily from the occupational therapist and social work team between 21/01/22 and 01/02/22. Staff at the hospital

said there should be more activity and that shortage of staff was a factor. The service is currently recruiting for one activity co-ordinator, one occupational therapist and one occupational therapy assistant. Two carers said activities did not always happen due to a shortage of staff. Three patients on Bowling ward said there are no activities on a weekend and two patients said there is not enough activities.

One care plan we reviewed on Bowling ward from 24 January 2022 until 7 February 2022 showed that activity was not happening every day even though there were activities listed on the activity planner for that time.

Managers did not always ensure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. A mandatory training matrix was provided to agency companies to ensure only staff with the required qualifications were sent to the service. The provider hired an external company to complete a yearly audit on the qualifications of agency staff. One agency company had 197 members of staff who worked for the provider and had audited 13 profiles in March 2021 and another agency company had 201 members of staff working for the provider and had audited 13 agency profiles in October 2020 remotely. Six agency companies out of 16 audited had failed their audits from October 2021 until December 2021. The qualification requirements were generic and were not service specific for the personality disorder unit.

The mandatory training programme did not meet the needs of patients and staff. The ward used dialectical behaviour therapy (DBT) as the core form of patient therapy, but this was not listed as mandatory training for staff. The service told us in March 2022 that 12 out of 25 members of ward staff had completed this.

Managers did not always give each new member of staff a full induction to the service before they started work. We requested induction checklists for a spot check of five agency staff who had worked on the ward in the previous two weeks of our inspection. We received no induction checklists but were provided with two security induction checklists.

Managers supported staff through regular, constructive appraisals of their work. 88% of staff had received an appraisal.

Managers supported staff through regular, constructive supervision of their work. 86% of staff had received clinical supervision and 95% of staff had received managerial supervision.

The ward had regular monthly team meetings with an average of 4-5 members of staff attending between November 2021 and January 2022.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers did not always make sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. 95% of staff had completed MHA awareness training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Inadequate

Personality disorder services

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The service had an independent mental health advocate who visited the hospital for 22.5 hours a week and split their time across all four wards.

Staff did not always explain to each patient their rights under the Mental Health Act in a way that they could understand, repeat as necessary and record it clearly in the patient's notes each time. One patient on Bowling ward had been at the hospital for six days before they were explained their rights and there was then a gap of one year with no record of an attempt to explain the patients' rights.

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

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

Informal patients did not always know that they could leave the ward freely. We reviewed the care records of one patient whose detention under the Mental Health Act had been rescinded without informing the patient's clinical care group, community team or care coordinator and saw five incidents where patients' movements were restricted due to "risk" whilst they were informal.

Are Personality disorder services caring?

Requires Improvement

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

Staff did not always treat patients with compassion and kindness. They did not always respect patients' privacy and dignity. They did not always understand the individual needs of patients and support patients to understand and manage their care, treatment, or condition.

Staff were not always discreet, respectful, and responsive when caring for patients. The December 2021 Bowling ward staff meeting minutes state there is a concern about how the negative staff culture can have an effect on the patients. A formal complaint had been made in November 2021 by a staff member on Bowling ward about staff using the incorrect pronouns for patients and one patient on Bowling ward told us that a staff member used the patient's door numbers to address them. The CQC had received a complaint from a patient on Bowling ward in January 2022 that the windows offered no privacy at night-time, and this was listed on the managers daily communication meeting minutes on 5 February 2022. Two patients on Bowling ward told us that when someone has an incident in their bedroom or in the corridor there is no privacy given to the patients. One patient told us that agency staff did not always knock before entering the patients' bedrooms.

Staff did not always give patients help, emotional support and advice when they needed it and did not always support patients to understand and manage their own care treatment or condition. Two patients out of the four we spoke to, told us that they did not always receive a debrief following incidents of restraint. The service used dialectical behaviour therapy (DBT) on the ward and used a "24-hour rule" which states that all patients who engage in self-harm or who have been physically aggressive would not receive communication from staff until 24 hours later. The poster on the ward

Inadequate

Personality disorder services

stated that patients will not receive "DBT coaching and/or warm 1:1, lengthy discussions or 'heart to hearts' until the next day from 8 a.m." The service advised they follow the DBT guidance for this restriction however there was no provider policy in place. The rule was not individually risk assessed and was applied to all patients regardless of whether they were participating in the DBT therapy.

Patients said staff did not treat them well or behave kindly. All four patients we spoke to on the personality disorder ward said there were not enough activities and that there is a large number of agency staff who do not know the ward, or the patients and they do not feel safe when agency staff are on shift. They said that they do not get a debrief if they have witnessed an incident on the ward. Three patients said that the current practices could be fatal.

Involvement in care

Staff involved patients in care planning and risk assessment. They ensured that patients had easy access to independent advocates.

Involvement of patients

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

Staff involved patients and gave them access to their care planning and risk assessments. We reviewed three care plans on Bowling ward which showed patient involvement.

Patients could give feedback on the service and their treatment and staff supported them to do this. The service told us that there was a patient and carer survey currently open for people to feedback about the ward. The hospital held a monthly people's council meeting with patient representatives attending from each ward and Bowling ward also held a monthly community meeting, however, there was no meeting in December 2021.

Staff made sure patients could access advocacy services. The service had an independent mental health advocate who visited the service regularly.

Involvement of families and carers

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

Staff did not always support, inform, or involve families or carers. Carers groups had been stopped since the start of the COVID pandemic and no alternative had been created. Two carers told us that the phone is not always answered, or calls returned and that they did not feel adequately informed about changes in the patients care including changes in medication and the nursing team.

Are Personality disorder services well-led?

Inadequate

Leadership

Leaders did not always have the skills, knowledge, and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service and approachable for patients and staff.

There had been three registered managers at the service since May 2021. From 31 January 2022 to 22 February 2022, during and after our inspection, we received six anonymous whistleblowing's from staff at the service. The concerns raised by all six members of staff stated they had no confidence in management. One member of staff stated that management were abusive, another member of staff stated some staff were bullies, and another member of staff stated that some members of the management team were racist.

Culture

Some staff did not feel respected, supported, and valued. They could not raise concerns without fear of retribution.

At the time of inspection, an independent investigation was being carried out after an anonymous whistleblowing alleging racism at the service had been sent to Lord Patel of Bradford. The investigation had resulted in four staff members being suspended and who currently remain suspended until the outcome of the investigation has been completed. A second independent investigation is being completed by a third-party company who had been hired by the provider to find a correlation between staff working and whistleblowing's received. Whistleblowing's were added to the services risk register in September 2020 and was given a rating of 12 which equates to catastrophic whilst culture and unhappy staff had been added in February 2021 and was also rated as a 12.

Although the service had 49 people leave the service in the previous six months, only four exit interviews had been completed. These were e-mailed to the staff members via an internet survey company and the results held by corporate human resources. The service did not ensure they were capturing and learning from staff who were leaving to be able to make effective changes.

In the March 2021 staff survey, 29% of respondents said if they could change one thing about their work place it would be the culture.

There had been 32 anonymous whistleblowing's and anonymous complaints received by the Care Quality Commission in the previous six months to inspection which spanned across all four wards. An overview of issues raised were:

- Bullying culture between staff members and from management
- High levels of agency staff who are not adequately trained
- Not enough staff to keep patients and staff safe which has led to high staff assaults, high number of patient restraints and observations not being complete in line with policy
- Racism against staff and patients

Governance

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

We observed a rota meeting where it was found that an agency nurse had been allocated to work on two different wards at the hospital that night and on the previous night. Agency staff could be registered with multiple agencies or be booked outside of their agency which is how double bookings can occur.

The ward did not hold profiles of agency staff, but the service had an agency profile folder at reception that was to be reviewed when agency staff came on site. The first page was a list of agency staff who were not to work at the hospital,

but the details of the staff were incomplete. We found the profile of one banned agency nurse within the agency staff profiles with no mention that they were banned. We found two agency staff members, one support worker and one nurse, had profiles with two different agencies and the nurse only had their PIN number on one of the profile pages. The rotas we reviewed did not always list last names or job roles of the agency staff working.

Not all agency staff received an induction to the ward and the service stated that not all induction records were available to review. We requested to view 20 induction checklists for the whole service for agency staff who had worked the two weeks prior to our inspection. The service was only able to provide four. The service advised that paper documents relating to induction were only accessible from 2015 onwards, however, only one member of agency staff had a start date prior to 2015.

Cleaning records were not always completed and required repairs to the service were not always escalated to the correct people for action. There was not always enough adequately staff on the ward and not all staff had completed their required training.

Management of risk, issues, and performance

Teams did not have access to the information they needed to provide safe and effective care.

The service had 25 open enquiries with the Care Quality Commission from 18 October 2021 to 22 February 2022. Nine of the enquiries have never received a response from the service despite our requests.

We had received a whistleblowing on 16 January 2022 from an anonymous staff member about the lack of staffing at the hospital. We asked the service to review their staffing needs versus actual for the previous two weeks and they were only able to provide one weekends worth of data. The service requested an extension to be able to provide the additional data, but this was not received.

Information management

Staff did not collect analysed data about outcomes and performance or engage actively in local and national quality improvement activities.

Engagement

Managers did not always actively engage with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.
Staff did not always carefully plan patients' discharge and work with care managers and coordinators to make sure this went well. Two NHS trusts informed us that a patient's community team, clinical commissioning group and care co-ordinator had not been informed about a patient's discharge from the Mental Health Act until three days after it had been rescinded. This meant that the patient did not have appropriate discharge planning meetings and Mental Health Act Section 117 after care in place.

Inadequate

Forensic inpatient or secure wards

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Well-led	Inadequate

Are Forensic inpatient or secure wards safe?

Inadequate

Safe and clean care environments

Wards were safe, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough ligature risk assessments of all wards areas and removed or reduced any risks they identified. However, the risk assessment completed September 2021 was not on Bronte ward at the time of our visit and could only be accessed on the computer. We were due to complete a tour of Shelley ward on our second visit to the service but there was a COVID outbreak on the ward on that day so we could not go on the ward, however, we had accessed the ward to complete patient interviews previously and had no concerns about the safety or cleanliness of the ward.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff could not always observe patients in all parts of the wards. Bronte ward did have mirrors for blind spots, but some rooms were not covered by these.

Maintenance, cleanliness, and infection control

Ward areas were well maintained, well-furnished and fit for purpose.

Staff did not make sure cleaning records were up-to-date and the premises were clean. There were multiple gaps in cleaning records across both Bronte ward and Shelley ward and not all assurance checks had been completed.

Staff followed infection control policy, including handwashing.

Seclusion room

The seclusion room on Shelley ward allowed clear observation and two-way communication. It had a toilet and a clock. Bronte ward did not have a seclusion room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. A monthly clinic room audit completed by the hospital's visiting pharmacist showed generally good compliance with policy. Repeated issues with the labelling of medicines for individual use, such as inhalers, had been identified from August 2021 to January 2022 but this had been addressed at the most recent check in January 2022.

Staff did not always check, maintain, and clean equipment. We reviewed the Bronte ward clinic room records for November 2021 to January 2022 and found that cleaning records, room temperature checks, and fridge temperature checks had not always been completed. Of the last three months of fridge temperature checks reviewed there were five dates that had not been completed. The emergency bag was torn on one side and the controlled drugs cabinet had a faulty lock. We reported this to the manager on site.

Safe staffing

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

Nursing staff

Bronte ward did not have enough nursing and support staff to keep patients safe. We reviewed the rota from the week commencing 17 January 2022. There were two nurses required on each shift but on 22 January 2022 and 23 January 2022 there was only one nurse on each day shift and on 20 January 2022 there was only one nurse on the night shift. On 17 January 2022, 20 January 2022, 21 January 2022, and 22 January 2022 the service was below the required number of support workers during the day shift. Staff on Bronte ward told us that they often did not have enough staff and that they felt a lot of pressure to complete multiple tasks at the same time.

There were no nurse vacancies and two support worker vacancies on Bronte ward and two nurse vacancies and no support worker vacancies on Shelley ward.

The service had high rates of bank and agency nurses and support workers. From January 2021 to January 2022 Bronte ward had used agency staff for 4,648.8 shifts and bank staff for 1,073.1 shifts. Shelley ward had used agency staff for 1,806.9 shifts and bank staff for 202.3 shifts.

Managers did not limit their use of bank and agency staff and request staff familiar with the service. Two carers of patients we spoke to said agency staff were less understanding and helpful. From 1 October 2021 to 31 December 2021, the services key performance indicators report stated that Bronte ward had used 58% of agency nurse staff and 185% of agency support workers who were not contracted and used on an ad-hoc basis. Shelley ward reported using 29% of agency nurse staff and 37% of agency support workers who were not contracted and used on an ad-hoc basis.

Managers did not make sure all bank and agency staff had a full induction and understood the service before starting their shift. We requested induction checklists for a spot check of five agency staff who had worked on Bronte or Shelley ward in the previous two weeks of our inspection. We were provided with three induction checklists on Shelley ward and no induction checklists on Bronte ward. Shelley ward also provided two security checklists and Bronte ward provided three security checklists. The hospital had listed use of agency on their risk register stating, “staff unfamiliar with the wards, patients and procedures could pose a risk to the safety and quality of care in the Hospital. We are averaging 40% usage.”

The service had high turnover rates. Across all three core services there was a turnover rate of 52% for the previous 12 months. From August 2021 to January 2022 there were 49 members of staff had left the hospital. This was higher than our previous report in May 2021 of 31%. The low secure forensic wards had an average turnover rate from November 2021 to January 2022 of 15%.

Managers supported staff who needed time off for ill health. The low secure forensic wards had an average sickness rate of 7% from November 2021 to January 2022. The hospital had an average sickness rate of 7% for all three core services for the previous 12 months which is higher than our previous report in May 2021 of 5%.

Managers calculated and reviewed the number and grade of nurses, and support workers for each shift. The managers at the service had a weekly rota meeting to review the staffing across the hospital.

The ward manager could adjust staffing levels according to the needs of the patients. Observation levels of patients were taken into account when deciding staff numbers. After our inspection the service implemented a daily review of staffing in the service.

Patients had regular one to one sessions with their named nurse.

Patients sometimes had their escorted leave or activities cancelled. Shelley ward had received a formal complaint from a patient in January 2022 because they had been unable to utilise their leave and that the walking groups had been cancelled due to a shortage of occupational therapy staff.

Staff did not always share key information to keep patients safe when handing over their care to others. We observed one handover on Bronte ward, but this was not documented and none of the staff were making notes to ensure they would remember the information provided. The lead of the handover asked the staff if they had missed anyone when providing an update which was concerning. We reviewed the handover documents that were available and found 15 handovers that had not been completed in January 2022. Management on Bronte ward did tell us they were hoping to improve the communication with staff so they can support patients appropriately. Bronte staff meeting minutes from November 2021 note that a patient's shopping had been unhealthy and that this was possibly down to staff not knowing the patient or their diet plan.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Not all staff had completed and kept up to date with their mandatory training. The five staff on Bronte ward and the two staff on Shelley ward who required electrocardiogram (ECG) training were not up to date on their training. On Bronte ward, 67% of staff had completed the pharmacy e-learning and medication competency training. On Shelley ward, 57% of staff were up to date on their emergency first aid at work including basic life support with an automated external defibrillator training and 68% of staff were up to date on their ligature rescue training.

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

Assessing and managing risk to patients and staff

Staff did not always identify and respond to any changes in risks to, or posed, by patients. Staff did not participate in a restrictive intervention's reduction programme, which met best practice standards.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. 83% of staff were up to date on their risk assessment training on Bronte ward and 80% of staff on Shelley ward.

Inadequate

Forensic inpatient or secure wards

Management of patient risk

Staff did not always identify and respond to any changes in risks to, or posed by, patients. In January 2022 a patient on Bronte ward, who was supported by three members of staff, entered another patient's bedroom, who was being supported by an additional two members of staff and was able to assault the patient. The perpetrator was able to make contact with the victim despite there being five members of staff to support the patients and keep them safe from harm.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The provider had an up-to-date policy that was followed, and body searches were only completed with agreement from the responsible clinician.

Use of restrictive interventions

Bronte ward had used restraint on patients 220 times from November 2021 until January 2022. There was a care planned and risk assessed restraint daily for one patient which accounts for 92 of the restraints. Shelley ward had used restraint on one patient once in November 2021.

Staff did not participate in a restrictive intervention's reduction programme, which met best practice standards. We requested information about the provider's restrictive interventions programme and were provided with the wards blanket rule audit and meeting minutes. We did request this information for a second time to ensure restraint, seclusion and rapid tranquilisation were not included and were advised again that the programme was in relation only to blanket rules. Both Bronte ward and Shelley ward's blanket rule list did not list the observation of mail opening as a restriction on patients, however, three patients on Shelley ward said they always had to open mail in front of staff and one patient on Bronte ward said it depended on which staff were in if they required you to open mail in front of them.

Shelley ward had not used rapid tranquilisation from November 2021 until January 2022.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Bronte ward had two incidents of seclusion in December 2021 and January 2022.

Safeguarding

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

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

Staff were kept up to date with their safeguarding training. 83% of staff on Bronte ward and 100% of staff on Shelley ward were up to date on the intermediate safeguarding adults at risk training.

The safeguarding team knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Children were able to visit patients in the hospital visiting room off the ward. Whenever a child was due to visit the service, the safeguarding team had a process in place to ensure there was no known risk and all interested third parties agreed to the visit. We observed the safeguarding team liaising with police and safeguarding services to ensure the safety of the children of a patient.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers did not take part in serious case reviews.

Inadequate

Forensic inpatient or secure wards

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. The service used a combination of electronic and paper records, and records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines.

The service had systems and processes in place to safely store, administer and record medicines use. We reviewed three prescription charts; these were clearly presented to show the treatment people had received. Patients were supported to self-administer medicines, and where possible, this was kept under review to help ensure medicines were handled safely. The ward checks of mental health act paperwork in January 2022 for medicines showed no discrepancies.

Staff stored and managed all medicines and prescribing documents safely. However, only 67% of staff had completed the pharmacy e-learning and medication competency training on Bronte ward.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. A review of patient's medicines and consideration of any individual physical health needs was completed as part of the monthly ward rounds with the consultant and wider team. A self-reporting tool was used to monitor for potential side effects of antipsychotic medicines.

Physical health monitoring following rapid tranquilisation (medicine given to manage aggression or agitation) was audited by the hospital. The report showed that rapid tranquilisation was infrequently used on these wards. However, the audit showed poor compliance (14% against policy) on last documented use in September 2021. An action plan had been put in place to provide supervision to nursing staff about the requirements for physical health monitoring post rapid tranquilisation, completed November 2021.

Medicines audit and incidents were shared at the hospital clinical governance meeting and cascaded for action and learning by ward managers at ward staff meetings. However, only limited information was shared from clinical audits completed by the pharmacist. For example, the hospital did not have an action plan in response to an antibiotic audit which was completed in November 2021.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Managers did not always investigate incidents.

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

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

The service had no never events on any wards.

Staff understood the duty of candour. However, two external organisations reported to us that there were concerns that the low secure forensic wards were not fully open and transparent with patients.

Inadequate

Forensic inpatient or secure wards

Managers debriefed and supported staff after any serious incident. Bronte ward held a debrief session for all staff after each shift, however, we were told by some staff that this only happened if particular management were on shift. The hospital had a wobble room where staff could go if they needed time out.

Managers did not always investigate incidents thoroughly. Despite our requests, we have not received the investigation report from an incident on Bronte ward in December 2021. We have also not received a response to our request for the service's response to a patient complaint we received in January 2022 about an agency staff member.

Are Forensic inpatient or secure wards effective?

Requires Improvement

Skilled staff to deliver care

The service did not always have access to the full range of specialists required to meet the needs of patients on the wards. They did not always support staff with appraisals and supervision.

The service did not always ensure that patients had access to a consistent range of specialists to meet the needs of the patients on the ward. There had been five responsible clinicians on Bronte ward from January 2021 until February 2022. There had been five responsible clinicians on Shelley ward since January 2021. There had been two formal complaints from patients on Shelley ward in December 2021 about the lack of progression due to a delay in response to the Ministry of Justice (MOJ) and to another third-party organisation where evidence of the psychology therapy being provided to the patients had been requested. One delay was 12 months, and another was 2 months.

During our review of the communication meeting minutes we saw that there was a range of between two to four people off sick daily from the occupational therapist and social work team between 21/01/22 and 01/02/22. Staff at the hospital said there should be more activity and that shortage of staff was a factor. The service is currently recruiting for one activity co-ordinator, one occupational therapist and one occupational therapy assistant. Two carers said activities did not always happen due to a shortage of staff. Two out of the three patients we spoke to on Bronte ward told us that there was not a lot of activities. Three out of the four patients on Shelley ward told us there were no activities on a weekend. Shelley ward had fed back to the management team that from 28/01/22 onwards there would be no occupational therapist or occupational therapist assistant in the coming weeks due to the current occupational therapist leaving and the patients had also raised this as a concern at the January 2022 people's council meeting.

Managers did not always ensure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. A mandatory training matrix was provided to agency companies to ensure only staff with the required qualifications were sent to the service. The provider hired an external company to complete a yearly audit on the qualifications of agency staff. One agency company had 197 members of staff who worked for the provider and had audited 13 profiles in March 2021 and another agency company had 201 members of staff working for the provider and had audited 13 agency profiles in October 2020 remotely. Six agency companies out of 16 audited had failed their audits from October 2021 until December 2021. Each ward did not hold profiles of the agency staff but there was an agency profile folder at reception that was to be reviewed when agency staff came on site. A member of staff on Bronte ward told us that they relied on agency staff to tell them their experience and qualifications before being allocated to certain duties. Some bank staff we spoke to said they were not at the service for long periods of time but when on duty were allocated to activities, such as security, that they had not received training on.

Inadequate

Forensic inpatient or secure wards

Managers did not always give each new member of staff a full induction to the service before they started work. We requested induction checklists for a spot check of five agency staff who had worked on the wards in the previous two weeks of our inspection. We received three induction checklists and two security induction checklists for Shelley ward and three security induction checklists and no induction checklists for Bronte ward. For the ten members of staff requested we received three induction checklists in total.

Managers did not always support staff through regular, constructive appraisals of their work. Bronte ward had only completed 46% of appraisals for staff. However, Shelley ward had completed appraisals for all their staff.

Managers did not always support staff through regular, constructive supervision of their work. On Bronte ward only 70% of staff had received clinical supervision when expected and only 69% of staff had received managerial supervision. All clinical supervision had been completed on Shelley ward and 94% had received managerial supervision.

Both wards had regular monthly team meetings.

Are Forensic inpatient or secure wards caring?

Requires Improvement

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

Staff did not always treat patients with compassion and kindness. They did not always respect patients' privacy and dignity. They did not always understand the individual needs of patients and did not always support patients to understand and manage their care, treatment, or condition.

Staff were not always discreet, respectful, and responsive when caring for patients. On Bronte ward one staff member said staff argue in front of patients and one staff member told us that they had heard and reported to management that they had heard a staff member tell a patient they stink. Four staff members on Bronte ward said they felt patient care was not up to standard, with one stating that cleaning came before the patients, another said they do not see progression for the patients and that the ward feels like a stop gap, another said the ward lacks the ability to give person centred care. One patient on Shelley ward told us some staff speak to them badly.

Involvement in care

Staff did not always involve patients in care planning and risk assessment. However, they ensured that patients had easy access to independent advocates.

Involvement of patients

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

Staff did not always involve patients and give them access to their care planning and risk assessments. On Bronte ward, one patient said no patients are allowed copies of their care plan and one patient's care plan that we looked at lacked patient input. Another care record we looked at had patient views, but the status of the patient had changed since and the patients' views had not been updated following the change.

Inadequate

Forensic inpatient or secure wards

Patients could give feedback on the service and their treatment and staff supported them to do this. The service told us that there was a patient and carer survey currently open for people to feedback about the ward. The hospital held a monthly people's council meeting with patient representatives attending from each ward and each low secure forensic ward held a monthly community meeting, however, there was no meeting in December 2021.

Staff made sure patients could access advocacy services. The service had an independent mental health advocate who visited the service regularly.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff did not always support, inform, or involve families or carers. Carers groups had been stopped since the start of the COVID pandemic and no alternative had been created. Two carers told us that the phone is not always answered, or calls returned and that they did not feel adequately informed about changes in the patients care including changes in medication and the nursing team.

Are Forensic inpatient or secure wards well-led?

Inadequate

Leadership

Leaders did not always have the skills, knowledge, and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service and approachable for patients and staff.

There had been three registered managers at the service since May 2021. From 31 January 2022 to 22 February 2022, during and after our inspection, we received six anonymous whistleblowing's from staff at the service. The concerns raised by all six members of staff stated they had no confidence in management. One member of staff stated that management were abusive, another member of staff stated some staff were bullies, and another member of staff stated that some members of the management team were racist.

Culture

Some staff did not feel respected, supported, and valued. They could not raise any concerns without fear of retribution.

At the time of inspection, an independent investigation was being carried out after an anonymous whistleblowing alleging racism at the service had been sent to Lord Patel of Bradford. The investigation had resulted in four staff members being suspended and who currently remain suspended until the outcome of the investigation has been completed. A second independent investigation is being completed by a third-party company who had been hired by the provider to find a correlation between staff working and whistleblowing's received. Whistleblowing's were added to the services risk register in September 2020 and was given a rating of 12 which equates to catastrophic whilst culture and unhappy staff had been added in February 2021 and was also rated as a 12.

Although the service had 49 employees leave the service in the previous six months, only four exit interviews had been completed. These were e-mailed to the staff members via an internet survey company and the results held by corporate human resources. The service did not ensure they were capturing and learning from staff who were leaving to be able to make effective changes.

In the March 2021 staff survey, 29% of respondents said if they could change one thing about their work place it would be the culture.

There had been 32 anonymous whistleblowing's and anonymous complaints received by the Care Quality Commission in the previous six months prior to inspection which spanned across all four wards. An overview of issues raised were:

- Bullying culture between staff members and from management
- High levels of agency staff who are not adequately trained
- Not enough staff to keep patients and staff safe which has led to high staff assaults, high number of patient restraints and observations not being complete in line with policy
- Racism against staff and patients

Governance

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

We observed a rota meeting where it was found that an agency nurse had been allocated to work on two different wards at the hospital that night and on the previous night. Agency staff could be registered with multiple agencies or be booked outside of their agency which is how double bookings can occur.

Each ward did not hold profiles of the agency staff, but the service had an agency profile folder at reception that was to be reviewed when agency staff came to site. The first page was a list of agency staff who were not to work at the hospital, but the details of the staff were incomplete. We found the profile of one banned agency nurse within the agency staff profiles with no mention that they were banned. We found two agency staff members, one support worker and one nurse, had profiles with two different agencies and the nurse only had their PIN number on one of the profile pages. The rotas we reviewed did not always list last names or job roles of the agency staff working.

Not all agency staff received an induction to the ward and the service stated that not all induction records were available to review. We requested to view 20 induction checklists for the whole service for agency staff who had worked the two weeks prior to our inspection. The service was only able to provide four. The service advised that paper documents relating to induction were only accessible from 2015 onwards, however, only one member of agency staff had a start date prior to 2015. There were inconsistent handovers to staff being provided.

There was not always enough adequately staff on the ward and not all staff had completed their required training or received appropriate supervision and appraisal. On Bronte ward, when we asked the staff to tell us how many people were on shift, they were unable to even though they were looking at the rota. They could not explain why they struggled with this

Management of risk, issues, and performance

Teams did not have access to the information they needed to provide safe and effective care.

Inadequate

Forensic inpatient or secure wards

The service had 25 open enquiries with the Care Quality Commission from 18 October 2021 to 22 February 2022. Nine of the enquiries have never received a response from the service despite our requests.

We had received a whistleblowing on 16 January 2022 from an anonymous staff member about the lack of staffing at the hospital. We asked the service to review their staffing needs versus actual for the previous two weeks and they were only able to provide one weekends worth of data. The service requested an extension to be able to provide the additional data, but this was not received.

Staff on Bronte ward told us they did not feel supported by management or that they could effectively make any positive changes.

Information management

Staff did not collect analysed data about outcomes and performance or engage actively in local and national quality improvement activities.

Engagement

Managers did not always actively engage other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

One NHS trust fed back that there had been a lack of response to requests for information and that observation levels for a patient on Bronte ward had been raised without informing the trust, whilst another NHS trust fed back that staff on Shelley ward could be difficult to get a hold of.

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

Inadequate

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Well-led	Inadequate

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

Inadequate

Safe and clean care environments

The service did not reduce or remove all risks identified on the ward. Staff could not always observe patients in all parts of the wards and staff did not always mitigate the risks to keep patients safe.

Safety of the ward layout

A tour of Denholme ward was attempted twice during the inspection period. On the first visit we were told whilst on the ward that the patients were unsettled, and it may be unsafe. On the second visit the ward was a red site due to a COVID outbreak. However, we were able to visit the clinic room on the ward.

The service did not reduce or remove all risks identified on the ward. Although staff completed and regularly updated thorough ligature risk assessments which identified fixed ligature points the service had plastic bags on the ward which were on the hospital contraband list. We were informed about a serious incident on Denholme ward in January 2022 where a patient had put a plastic bag over another patient's head. The service told us that a carrier bag was taken up to the ward by a staff member and that carrier bags had only recently been made a contraband item despite the contraband list being in place at the time of the incident.

Staff could not always observe patients in all parts of the wards and staff did not always mitigate the risks to keep patients safe. In February 2022, a patient was able to ligature whilst in seclusion in their bedroom. The system notes from that incident state this was due to the light in the patient's bedroom timing out. However, the incident record we reviewed on site stated that this was due to staff not observing the patient. The patient was then moved to the seclusion suite on the forensic male low secure ward where they then ligatured with anti-ligature clothing. We were informed by the service that this was not safeguarded against nor were CQC informed at the time. A CQC notification has since been received.

Maintenance, cleanliness, and infection control

Staff did not always make sure cleaning records were up to date. There was no sign off for the monthly walk around audit in December 2021. The seclusion suite checks which require sign off had not been done for 12 dates in January 2022 and there had been no sign off for two dates in January 2022 for the ward checks. Two of the four patients we spoke to told us that the ward was not clean. Six housekeeping weekend recording sheets in January 2022 and four Denholme ward housekeeping daily record sheets in January 2022 stated the housekeeping team were short staffed.

The 1 February 2022 morning communication meeting minutes stated that the kitchen window on Denholme ward had been shattered since October 2021. The schedule of works received from the service about building updates expected did not include any works on windows at the hospital. The windows at the hospital have been on the services risk register since September 2019 with a risk rating of 12 which equates to catastrophic on the services risk rating scale.

Seclusion room

There was a seclusion room on Denholme ward, however, we were unable to view as mentioned previously.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

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

Nursing staff

The ward had did not have enough nursing and support staff to keep patients safe. We reviewed two weeks rotas from the week commencing 31 January 2022 to 13 February 2022. There were five shifts where they did not have the two required nurses and were running on one nurse of which four were staffed solely by agency nurses with one being a non-regular agency nurse at the service. There was one shift on 28 January 2022 where there were no nurses on duty.

The ward had high vacancy rates. There were six vacancies for nurses and three vacancies for support workers.

The ward had high rates of bank and agency nurses and support workers. From January 2021 to January 2022 the ward had used agency staff for 2953.6 shifts and bank staff for 122.2 shifts.

Managers did not limit their use of bank and agency staff and did not always request staff familiar with the service. One agency nurse we spoke to said they were concerned as they had no experience in a PICU and that they were often the only nurse on shift. For two shifts on the rotas we reviewed, there were only unregular agency nurses used, one shift did not have the required two nurses.

Managers did not make sure all bank and agency staff had a full induction and understood the service before starting their shift. We requested induction checklists for a spot check of five agency staff who had worked on the ward in the previous two weeks of our inspection. We received only one induction checklist and one security induction checklist. There was no evidence four of the five agency staff members had received an induction. The service could not tell us when the agency staff member, who we had received an induction checklist for, had started working at the hospital. We did see that this agency staff member had previously worked the night shift on Denholme ward on 29 January 2022, but their induction checklist was not completed until the 8 February 2022 despite the induction checklist stating, “Where the shift undertaken is an ad hoc shift the agency worker will commence work one hour before shift commences to allow a meaningful induction”. The hospital had listed use of agency on their risk register stating, “staff unfamiliar with the wards, patients and procedures could pose a risk to the safety and quality of care in the Hospital. We are averaging 40% usage.”

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

Inadequate

The service had high turnover rates. Across all three core services there was a turnover rate of 52% for the previous 12 months. From August 2021 to January 2022, 49 members of staff had left the hospital. This was higher than our previous report in May 2021 of 31%. Denholme ward had an average turnover rate from November 2021 to January 2022 of 6%.

Managers supported staff who needed time off for ill health. Denholme ward had an average sickness rate of 15% from November 2021 to January 2022. The hospital had an average sickness rate of 7% for all three core services for the previous 12 months which is higher than our previous report in May 2021 of 5%.

Managers did not always accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The managers at the service had a weekly rota meeting to review the staffing across the hospital. During our observation of this meeting, it was found that a nurse agency staff member had been allocated to work on Denholme ward and another ward at the hospital for the same shift that night and on the previous night. The required day and night support workers consistently stated four on the ward rotas, but this was regularly over staffed due to observations and levels, but this was not documented on the rota, so we were unable to see how many support workers were actually required.

The ward manager could adjust staffing levels according to the needs of the patients. Observation levels of patients were taken into account when deciding staff numbers. After our inspection the service implemented a daily review of staffing in the service. It was found that on Denholme ward from 4 February 2022 until 20 February 2022 they were short the required number of support workers on two day shifts and four night shifts and were short the required number of nurses on one night shift and one day shift.

Patients had regular one to one sessions with their named nurse.

Staff did not always share key information to keep patients safe when handing over their care to others. We found three dates in January where a handover document had not been completed. Some staff told us that agency staff do not know enough about the patients they are brought in to care for. One member of staff said the service needs a better way of sharing information as people do not always have the time to go through the daily notes to find out if a patient's risk or behaviours have changed.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. However, only 65% of staff were up to date with their personality disorder e-learning training.

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

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

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

Inadequate

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. Staff did not participate in a restrictive intervention's reduction programme.

Assessment of patient risk

Staff used a recognised risk assessment tool. However, the ward used a different risk assessment tool to the rest of the hospital.

Staff did not regularly review and update patients risk assessments following incidents. One patient had been part of a serious incident on the ward, but this was not mentioned on the patient's risk assessment despite numerous updates since. The same patient had two new incidents identified in their ward round and these were not included in the risk assessment. The patient had their observation levels decreased but there was no reason provided in the patient's risk assessment for the change.

Management of patient risk

Staff did not always know about all risks to each patient or act to prevent or reduce risks. The provider had a hospital wide contraband items list. However, this was not ward specific and was not reviewed regularly and updated depending on the patient group. The ward did have a blanket rules audit and regular meeting but not all of the items listed on the hospital wide contraband listed were reviewed. There was one patient on the ward who was a risk of using a contraband item to harm others, but the service was not aware of this.

Staff could not observe patients in all areas of the ward. A patient was able to ligature whilst in seclusion although the patient was on constant observations at the time. The records differ in their reason of this, one states that it was because the dimmer switch in the bedroom timed out and the other states that it was because a panel had not been removed.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The provider had an up-to-date policy that was followed, and body searches were only completed with agreement from the responsible clinician.

Use of restrictive interventions

Levels of restrictive interventions were high. The ward had used restraint on patients 151 times from November 2021 to January 2022.

Staff did not participate in a restrictive intervention's reduction programme, which met best practice standards. We requested information about the provider's restrictive interventions programme and were provided with the wards blanket rule audit and meeting minutes. We did request this information for a second time to ensure restraint, seclusion and rapid tranquilisation were not included and were advised again that the programme was in relation only to blanket rules. The blanket restrictions register states in April 2021 that "service users have access to mail; however, this is signed in and out by staff and also observed by staff on opening" and states it will be individually reviewed during patient's ward rounds. The patient record we reviewed said the restriction is due to a "risk of contraband items coming on the ward" and does not make reference to the patient. Some staff also told us this blanket restriction was in place for all patients.

Staff followed NICE guidance when using rapid tranquilisation. The ward had used rapid tranquilisation 94 times from November 2021 to January 2022.

When a patient was placed in seclusion, staff did not always keep clear records or follow best practice guidelines. The ward had used seclusion 23 times from November 2021 to January 2022. The system notes from a patient ligature incident whilst in bedroom seclusion in February 2022 stated this was due to the light in the patient's bedroom timing out. However, the incident record we reviewed on site stated that this was due to staff not observing the patient.

Safeguarding

Staff had training on how to recognise and report abuse and they knew how to apply it.

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

Staff kept up to date with their safeguarding training. All staff were up to date on the intermediate safeguarding adults at risk training.

The safeguarding team knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Children were able to visit patients in the hospital visiting room off the ward. Whenever a child was due to visit the service, the safeguarding team had a process in place to ensure there was no known risk and all interested third parties agreed to the visit. We observed the safeguarding team liaising with police and safeguarding services to ensure the safety of the children of a patient.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers did not take part in serious case reviews.

Staff access to essential information

Some staff did not always have easy access to clinical information.

Patient notes were not always comprehensive, and not all staff could access them easily. Staff told us that not all staff could access the patient records on the computer. The inspection team were able to navigate the care records with a laptop and login so it could be done, but it appeared this information had not been disseminated to the staff working on Denholme ward or that they had been given the same tools as we had been provided. The assurance report received from the service during the inspection noted that not all staff have access to the system and that paper copies of the handover notes should be printed out for their review. Our rota review from the previous two weeks evidenced that there had been multiple shifts on the ward that had used unregular agency nurses and they would not have been able to update the notes if they were unable to access the system. Our review of one patient records showed that not all incidents are captured in the notes and that the reasons for changes in the care being provided are not always evidenced.

The ward used a combination of electronic and paper records and during our review we found it difficult to navigate between the two systems.

Medicines management

The service had systems and processes in place to safely administer and record medicines use. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff had systems and processes in place to safely administer and record medicines use. We reviewed five prescription charts; these were clearly presented to show the treatment people had received. However, we saw one example where one more dose of medication had been administered within a 24h period when administration had gone over two days.

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

Inadequate

Since our previous inspection action had been taken to help ensure that injections administered to acutely unwell patients were managed and recorded in accordance with hospital policy. Physical health monitoring following rapid tranquilisation (medicine given to manage aggression or agitation) was mostly clearly completed with 99% compliance with policy in the December 2021 hospital audit.

A review of people's medicines and consideration of any individual physical health needs was completed as part of ward rounds with the consultant and wider team. A self-reporting tool was used to monitor for potential side effects of antipsychotic medicines. The hospital's Mental Health Act audit in January 2022 found that the appropriate authorities were in place for patients' currently prescribed medicines.

Individual care plans were in place for people where there was a risk of violence or aggression. These plans included information about the use of any prescribed 'when required' medicines. However, we saw two examples where care plans had not been kept up to date with changes to the patient's prescription.

The hospitals visiting pharmacist provided the national medicines safety alerts to the ward, however repeated monthly audits from August 2021 to January 2022 identified some delays in the ward acknowledging these.

Medicines were stored securely in the clinic room and checks of the room and fridge temperatures were completed to ensure they were suitable for medicines storage. Emergency equipment and medicines were available on the ward and in date.

Medicines audit and incidents were shared at the hospital clinical governance meeting and cascaded for action and learning by ward managers at ward staff meetings. However, only limited information was shared from clinical audits completed by the pharmacist. For example, the hospital did not have an action plan in response to an antibiotic audit which was completed in November 2021.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not recognise incidents and report them appropriately. Managers did not always investigate incidents and share with the appropriate organisations.

Staff did not always know what incidents to report and how to report them. The cause of one incident had been reported differently on two different systems. The incident was not reported to the local authority safeguarding team or to the Care Quality Commission.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. The hospital also had a wobble room where staff could go if they needed time out.

Managers did not always investigate incidents thoroughly. Despite our requests, we have not received investigation reports for four incidents between November 2021 and January 2022 on Denholme ward. We have also not received the outcome of the services safeguarding referral to the local authority for two incidents. We have not received a response from the service at all about five separate notifications that they had submitted to the Care Quality Commission despite our requests.

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

Inadequate

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

Requires Improvement

Skilled staff to deliver care

The ward team did not always have access to the full range of specialists required to meet the needs of patients on the ward. Managers did not always provide an induction programme for new staff.

The service did not always ensure that patients had access to a full consistent range of specialists to meet the needs of the patients on the ward. During our review of the communication meeting minutes we saw that there was a range of between two to four people off sick daily from the occupational therapist and social work team between 21/01/22 and 01/02/22. Staff at the hospital said there should be more activity and that shortage of staff was a factor. One patient on the ward said that the activities were not suitable for the patient age group, stating that one activity was colouring. The service is currently recruiting for one activity co-ordinator, one occupational therapist and one occupational therapy assistant.

Managers did not always ensure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. A mandatory training matrix was provided to agency companies to ensure only staff with the required qualifications were sent to the service. The provider hired an external company to complete a yearly audit on the qualifications of agency staff. One agency company had 197 members of staff who worked for the provider and had audited 13 profiles in March 2021 and another agency company had 201 members of staff working for the provider and had audited 13 agency profiles in October 2020 remotely. Six agency companies out of 16 audited had failed their audits from October 2021 until December 2021.

Managers did not always give each new member of staff a full induction to the service before they started work. We requested induction checklists for a spot check of five agency staff who had worked on the ward in the previous two weeks of our inspection. There was no evidence four of the five agency staff members had received an induction.

Managers supported staff through regular, constructive appraisals of their work. 92% of staff had received an appraisal.

Managers supported staff through regular, constructive supervision of their work. 94% of staff had received clinical supervision and 94% has received managerial supervision.

The ward had regular monthly team meetings.

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

Staff did not always explain to each patient their rights under the Mental Health Act in a way that they could understand, and staff did not always make sure patients could take section 17 leave.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. All staff had completed their Mental Health Act awareness training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

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

Inadequate

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. The service had an independent mental health advocate who visited the hospital for 22.5 hours a week and split their time across all four wards.

Staff did not always explain to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. For one patient, there was no evidence that their rights had been explained to them at all whilst detained under Section 2 of the MHA. The patient was then detained under Section 3 of the MHA and there is no evidence that the patient was explained their rights for a further 17 days. For some of the patients on Denholme ward they were not explained their rights in line with their care plans or completed on planned review dates.

Staff did not always make sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. One patient's care record we reviewed said that the patient had "been informed of the Government's guidance that you can only go out to exercise once daily and purchase essential items at the discretion of the ward." The rule for once daily exercise due to the COVID pandemic is no longer in place and not correct.

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

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

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

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

Requires Improvement

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

We were unable to observe staff interactions with patients on the ward due to the reasons stated earlier. However, all four patients we spoke to said they did not feel safe on the ward due to other patients attempting to physically assault them.

From 1 December 2021 until 28 February 2022 the Care Quality Commission received 47 notifications of patient-on-patient assaults on the ward.

Involvement in care

Staff did not always involve patients in care planning and risk assessment or actively seek their feedback on the quality of care provided. They did not always ensure that patients had easy access to independent advocates.

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

Inadequate

Involvement of patients

Staff did not always involve patients in their care planning and risk assessments. One patient's care plan in January 2022 states that the patient was too unwell to provider their views on their care plan, however, on the same date the daily notes state the same patient engaged in a one-to-one discussion with the activity co-ordinator about activities. There is no evidence that anyone attempted to discuss the care plan with the patient.

Patients could give feedback on the service and their treatment and staff supported them to do this. The service told us that there was a patient and carer survey currently open for people to feedback about the ward. The hospital held a monthly people's council meeting with patient representatives attending from each ward and Denholme ward also held a weekly community meeting, however, there was no meeting in December 2021.

Staff did not always make sure patients could access advocacy services. On the second week of our inspection the independent mental health advocate (IMHA) was unable to physically go to Denholme ward due to the COVID outbreak on the ward. The IMHA asked if the ward could facilitate an online meeting but was told by the service that this was not possible due to the ward only having one laptop and being short staffed. The service told the IMHA that the laptop had sensitive information on so a meeting could only be facilitated if a staff member was available to sit with the patients.

Involvement of families and carers

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

Staff did not always support, inform or involve families or carers. Carers groups had been stopped since the start of the COVID pandemic and no alternative had been created. We were provided with contact numbers for two relatives and carers of the patients on the psychiatric intensive care unit, but they were not available. One patient told us that their relative had contacted the service for information and had not received a response.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Inadequate

Leadership

Leaders did not always have the skills, knowledge, and experience to perform their roles. They did not always have a good understanding of the services they managed and were not always visible in the service and approachable for patients and staff.

There had been three registered managers at the service since May 2021. From 31 January 2022 to 22 February 2022, during and after our inspection, we received six anonymous whistleblowing's from staff at the service. The concerns raised by all six members of staff stated they had no confidence in management. One member of staff stated that management were abusive, another member of staff stated some staff were bullies, and another member of staff stated that some members of the management team were racist.

Culture

Some staff did not feel respected, supported, and valued. They could not raise concerns without fear of retribution.

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

Inadequate

At the time of inspection, an independent investigation was being carried out after an anonymous whistleblowing alleging racism at the service had been sent to Lord Patel of Bradford. The investigation had resulted in four staff members being suspended and who currently remain suspended until the outcome of the investigation has been completed. A second independent investigation is being completed by a third-party company who had been hired by the provider to find a correlation between staff working and whistleblowing's received. Whistleblowing's were added to the services risk register in September 2020 and was given a rating of 12 which equates to catastrophic whilst culture and unhappy staff had been added in February 2021 and was also rated as a 12.

Although the service had 49 people leave the service in the previous six months, only four exit interviews had been completed. These were e-mailed to the staff members via an internet survey company and the results held by corporate human resources. The service did not ensure they were capturing and learning from staff who were leaving to be able to make effective changes.

In the March 2021 staff survey, 29% of respondents said if they could change one thing about their work place it would be the culture.

There had been 32 anonymous whistleblowing's and anonymous complaints received by the Care Quality Commission in the previous six months to inspection which spanned across all four wards. An overview of issues raised were:

- Bullying culture between staff members and from management
- High levels of agency staff who are not adequately trained
- Not enough staff to keep patients and staff safe which has led to high staff assaults, high number of patient restraints and observations not being complete in line with policy
- Racism against staff and patients

Staff across all four wards told us that some staff were treated negatively compared to other staff members for various reasons including race and employment status.

Governance

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

We observed a rota meeting where it was found that an agency nurse had been allocated to work on two different wards at the hospital that night and on the previous night. Agency staff could be registered with multiple agencies or be booked outside of their agency which is how double bookings can occur.

The ward did not hold profiles of agency staff, but the service had an agency profile folder at reception that was to be reviewed when agency staff came on site. The first page was a list of agency staff who were not to work at the hospital, but the details of the staff were incomplete. We found the profile of one banned agency nurse within the agency staff profiles with no mention that they were banned. We found two agency staff members, one support worker and one nurse, had profiles with two different agencies and the nurse only had their PIN number on one of the profile pages. The rotas we reviewed did not always list last names or job roles of the agency staff working.

Not all agency staff received an induction to the ward and the service stated that not all induction records were available to review. We requested to view 20 induction checklists for the whole service for agency staff who had worked the two weeks prior to our inspection. The service was only able to provide four. The service advised that paper documents relating to induction were only accessible from 2015 onwards, however, only one member of agency staff had a start date prior to 2015.

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

Inadequate

Management of risk, issues, and performance

Teams did not have access to the information they needed to provide safe and effective care.

The service had 25 open enquiries with the Care Quality Commission from 18 October 2021 to 22 February 2022. Nine of the enquiries have never received a response from the service despite our requests.

We had received a whistleblowing on 16 January 2022 from an anonymous staff member about the lack of staffing at the hospital. We asked the service to review their staffing needs versus actual for the previous two weeks and they were only able to provide one weekends worth of data. The service requested an extension to be able to provide the additional data, but this was not received.

Information management

Staff did not collect analysed data about outcomes and performance or engage actively in local and national quality improvement activities.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Feedback from an NHS trust were positive about the engagement they had with the PICU service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider must ensure that patients receive safe care and treatment and prevent avoidable harm or risk of harm. The provider must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills, and experience to keep people safe. (Regulation 12) • The provider must ensure they review the contraband list for the hospital and the three separate core services and ensure these lists are clear and appropriate and do not contradict each other. (Regulation 12) • The provider must ensure that all staff have received training to complete service user observations. Including seclusion observation. (Regulation 12) • The provider must ensure that all staff are up to date on their mandatory training. (Regulation 12) • The provider must ensure that they introduce and follow a restrictive interventions reduction programme that follows best practice guidance. (Regulation 12) • The provider must ensure that clear and accurate records of medicines administration are maintained, and when indicated, that the appropriate mental health act authorities are in place. (Regulation 12)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider must ensure the current permanent staffing levels on the wards match the needs of the service and work to reduce the amount of agency staff used. (Regulation 18)

This section is primarily information for the provider

Requirement notices

- The provider must ensure that there are enough staff available seven days a week to be able to offer patients varied range of activities. (Regulation 18)
- The provider must ensure that effective handovers are completed and documented and that all staff are able to access patient information quickly and efficiently. (Regulation 18)
- The provider must ensure that all staff get appropriate supervision and appraisal. (Regulation 18)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service much ensure that they review the negative culture and chaotic nature of the wards so that they are able to assess, monitor and mitigate risks relating to the health, safety and welfare of patients and staff. (Regulation 17) • The provider must ensure there are robust governance arrangements in place for the allocation and induction of agency staff at the service. (Regulation 17) • The service must review their management systems so that there are effective structures in place to monitor and mitigate any risks relating the health, safety and welfare of patients and staff. (Regulation 17) • The service must ensure that effective governance processes are implemented and followed to ensure safe care and treatment of patients. (Regulation 17) • The service must conduct meaningful exit interviews with all staff who leave the service. (Regulation 17)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The service must ensure that people using the service receive consistent and appropriate person-centred care

This section is primarily information for the provider

Requirement notices

and treatment that is based on an assessment of their needs and preferences and are responsive to requests for information to ensure the continued progression of a person's treatment. (Regulation 9)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • The service must ensure that patients on the personality disorder ward are individually assessed for the most appropriate therapy and restrictions are based on an individual risk assessment. (Regulation 10) • The service must ensure that people using the service are treated with respect and dignity at all times whilst they are receiving care and treatment. (Regulation 10)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The provider must ensure that when patients are not detained under the Mental Health Act, that informed consent is gained from the informal patient and the legal rights of an informal patient are adhered to. (Regulation 13)