The Dene

Quality Report

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

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

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

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

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

Overall summary

On the evening of April 4 2018 and during the day on April 5 2018 we undertook an unannounced, focussed inspection of three wards at The Dene. We found the following areas of good practice:

- Each ward managed their environmental security by having a security lead for each shift who was responsible for the security of the ward. Staff carried alarms at all times which they signed in and out from the hospital reception at the start and end of each shift.
- Each ward had assessed risk posed by blind spots and ligatures and had detailed blind spot and ligature risk assessments. Each had an accompanying action plan to mitigate identified risks.
- All wards were clean, spacious and well maintained. Each ward had sufficient rooms and spaces for patients to use which provided a quiet space. These were all clean and had suitable furnishings. Clinic rooms on each ward were clean and had accessible resuscitation equipment that was checked regularly.
- Mandatory training was up to date across all wards. Staff were alerted when their training was due to expire so they could book on the relevant course. Bank or locum staff were not booked to work on the wards until all mandatory training had been completed. All staff had received safeguarding training and were aware of how to make a safeguarding alert to the local authority.

Summary of findings

- Staff updated risk assessments following incidents and completed a risk assessment of each patient on admission. Staff followed appropriate observation policies. If staff felt a patient required additional levels of observation then the nurse in charge could increase the level, and request additional staff if any additional one to one observations were needed.
- Interactions between staff and patients were positive. Patients reported that staff treated them well and that they felt safe and well looked after. Each ward had a weekly community meeting for patients to give feedback on the service they were receiving and make suggestions. The wards also had 'you said, we did' boards to highlight areas where changes had been made as a result of patient feedback.

However:

- Seclusion paperwork was not always completed fully and did not always correspond with what was recorded in the patient electronic record.
- Staff did not always complete follow up physical health checks on patients if this was indicated by their physical health scores.
- Not all staff reported being aware of outcomes of incidents or lessons learned from these.
- Not all patients we spoke with had a copy of their care plan.

Summary of findings

Contents

The Dene

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards

Summary of this inspection

Our inspection team

The team was comprised of five CQC inspectors, one inspection manager and three specialist advisors with experience of working in mental health in patient settings.

Why we carried out this inspection

We undertook an unannounced, focused inspection, following concerns we had received through intelligence monitoring. These included insufficient staffing levels, staff attitude towards patients, staff not having personal alarms and issues with restraint and the use of seclusion.

As this was not a comprehensive inspection, we did not pursue all key lines of enquiry. We visited three wards at the service. As we only focused on the issues of concern, we have not reconsidered the rating of this service.

How we carried out this inspection

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

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

At the previous comprehensive inspection in October 2016 we rated the service as good overall with effective, caring, responsive and well led all being rated as good. The safe domain was rated as requires improvement. The safe domain was rated as good following a focused inspection in June 2017. This inspection focused on the safe and caring domains only.

Before the inspection visit, we reviewed information that we held about these services and had received fortnightly updates from the hospital following media interest in the service.

During the inspection visit, the inspection team:

- visited three of the wards and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with the managers or acting managers for each of the wards we visited
- spoke with 18 other staff members including nurses and healthcare assistants
- spoke with two ward doctors and visiting GP
- attended and observed three hand-over meetings
- looked at 20 care records and 21 prescription cards of patients
- carried out a specific check of the medication management on three wards
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

Information about The Dene

The Dene is a modern purpose-built hospital providing acute and psychiatric intensive care units as well as specialised medium and low secure services for people with mental health needs, mild learning disabilities or problems with substance misuse.

The hospital currently has six working wards which comprise two male wards, one acute, one high dependency unit; one female high dependency unit, one medium secure female ward, one low secure female ward and a specific personality disorders unit for female patients with a diagnosis of emotionally unstable personality disorder.

The hospital was last inspected fully in October 2016. At the October 2016 inspection CQC issued one requirement notice in relation to ligature risk assessments and mitigation plans. This related to the following regulation under the Health and Social Care Act (Regulated Activities) Regulations 2014:

• Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment

A requirement notice is issued by CQC when an inspection identifies that the provider is not meeting essential standards of quality and safety. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

A follow up inspection took place in June 2017 at which the required standards had been met and the requirement notice was met.

What people who use the service say

Patients told us they felt safe on the wards and well treated by staff. They reported that the food was good and staff respected their confidentiality by always knocking on their bedroom door before entering. Patients felt that sometimes leave or activities were cancelled or re-arranged, but also felt there were enough members of staff on duty. Not all patients had a copy of their care plan, but those we spoke with stated they were involved in their care and treatment on the ward.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following areas of good practice:

- Each ward had a security lead for each shift who was responsible for environmental security on that shift. Staff carried alarms at all times which they signed in and out from the hospital reception at the start and end of each shift.
- Each ward had a blind spot risk assessment to identify areas of risk and each had an accompanying action plan to mitigate identified risks. Staff had identified any ligature anchor point risks and these were documented on each ward in a comprehensive ligature risk audit. This contained actions to mitigate any identified risks.
- All wards were clean, spacious and well maintained. Each ward had quiet rooms and spaces for patients to use which were clean and had suitable furnishings. Clinic rooms on each ward were well stocked and had accessible resuscitation equipment that was checked regularly.
- Staffing levels could be adjusted on each ward depending on the number of patients on the ward, and the amount of one-to-one patient observations. Each ward had a minimum of two qualified nursing staff on each day shift and one at night. All shifts were covered with each ward using regular agency locum staff to cover as required.
- All staff mandatory training was up to date across all wards. The hospital had a robust system in place to ensure that staff were notified whenever any mandatory training was due to expire. If a bank or locum staff member did not have full mandatory training compliance they would not be able to work on the wards until this had been completed. All staff had received training in safeguarding and were aware of how to make a safeguarding alert to the local authority.
- Staff completed a risk assessment of each patient on admission. Staff updated these following incidents and at regular intervals to ensure they remained up to date. Staff followed appropriate observation policies. If staff felt a patient required additional levels of observation then the nurse in charge could increase the level, and request additional staff if any additional one to one observations were needed.

However:

Summary of this inspection

- Not all seclusion paperwork was completed fully and did not always correspond with what was recorded in the patient electronic record.
- Following routine patient physical health checks not all patients were re-checked within appropriate timescales or within the timescale indicated by their health check score.
- Not all staff reported being aware of outcomes of incidents or lessons learned from these.

Are services effective?

At the last comprehensive inspection in October 2016 we rated effective as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services caring?

We found the following areas of good practice:

- We observed numerous positive interactions between staff and patients. Patients reported that staff treated them well and that they felt safe and well looked after.
- Patients we spoke with told us that staff gave them information about the treatment they were receiving to help them understand and better manage their condition.
- Staff maintained patient confidentiality and patients reported that staff always knocked before entering their bedroom.
- Each ward had a weekly community meeting for patients to give feedback on the service they were receiving and make suggestions. The wards also had 'you said, we did' boards to highlight areas where changes had been made as a result of patient feedback.
- Families and carers were invited to patient care programme approach meetings to provide input into any care decisions.

However:

- Not all patients we spoke with had a copy of their care plan.

Are services responsive?

At the last comprehensive inspection in October 2016 we rated responsive as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Summary of this inspection

Are services well-led?

At the last comprehensive inspection in October 2016 we rated well led as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Detailed findings from this inspection

Mental Health Act responsibilities

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

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

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Safe and clean environment

Safety of the ward environment

- Each ward had a security lead for each shift who was responsible for environmental security on that shift. This included ensuring patient observations were completed, cutlery was counted before and after each mealtime, checking the ward for any prohibited items and the overall security of the ward. This role was carried out by trained healthcare assistants to ensure an appropriate member of staff undertook this role.
- There were blind spots on each of the wards, although this was managed by use of staff observation and the use of convex mirrors. Each ward had a blind spot risk assessment to identify areas of risk and each had an accompanying action plan to mitigate identified risks.
- Staff had identified any ligature anchor point risks and these were documented on each ward in a comprehensive ligature risk audit that had recently been completed. This contained actions to mitigate any identified risks.
- Each ward was single sex and so complied with Department of Health guidance on single sex accommodation. All patient bedrooms had ensuite shower rooms.
- Staff carried alarms at all times which they signed in and out from the hospital reception at the start and end of each shift. Staff also had their own keys which they signed for at the beginning of their shift and returned when they left. The nurse in charge of each shift also carried the medicine keys to ensure that these were safe and no patients could enter the clinic room or access medicines unsupervised.

Maintenance, cleanliness and infection control

- All wards were clean, spacious and well maintained. Each ward had quiet rooms and spaces for patients to use which were clean and had suitable furnishings.
- Cleaning records showed that the ward was cleaned regularly and cleaning records were up to date.
- Staff adhered to infection control principles and we saw hand gel dispensers outside each ward and in the reception area for staff and visitors to use prior to going on to the ward.

Seclusion room

- The seclusion room on Elizabeth Anderson ward was well designed and equipped. There was a visible clock, observation panels and hatch at a suitable height and a shower and toilet facilities.
- The seclusion room on Michael Shepherd ward was adequate, but the hatch was low in the door making it difficult to use and posed a risk of patients getting their arm through when this was opened. However, there was a clock and appropriate shower and toilet facilities.
- The seclusion room for Michael Shepherd was not located on the ward, which meant that staff had to accompany patients off the ward to take them to seclusion. This could potentially cause issues of patient safety and leave the ward short staffed whilst the patient was transferred.

Clinic room and equipment

- Clinic rooms on each ward were well stocked and had accessible resuscitation equipment that was checked regularly. Staff checked medicines and equipment regularly and monitored fridge temperatures daily.

Safe staffing

Nursing staff

- Staffing levels could be adjusted on each ward depending on the number of patients on the ward, and the amount of one-to-one patient observations. The wards had a staffing ladder which showed the minimum number of staff required on shift. For each patient on one-to-one observations the ward manager could request an additional healthcare assistant so that the staff member completing observations would not be taken from the shift numbers.
- Each ward had a minimum of two qualified nursing staff on each day shift and one at night. There was a night shift and day shift nurse co-ordinator for the hospital as a whole each day who could arrange for cover and additional staff if required.
- Staff worked a shift pattern of 7.30am – 8pm, and 7.30pm – 8am. There was always a minimum of two qualified nurses on each day shift and one for each night shift. The management team held a multidisciplinary team meeting every morning at which staffing levels for the hospital were discussed. If a ward was under staffed, staff could be moved from another ward to cover if that did not leave a ward short.
- Each ward had staff vacancies. Elizabeth Anderson ward had seven nurse vacancies and 11 healthcare assistant vacancies; Michael Shepherd ward had three nurse vacancies and nine healthcare assistant vacancies and Helen Keller ward had six nurse vacancies and 11 healthcare assistant vacancies. The hospital was proactively recruiting to these vacancies and could offer interviews to potential staff at short notice.
- Despite the high level of staff vacancies we saw rotas which showed shifts were covered and the wards were not under-staffed. All shifts were covered with each ward using regular agency locum staff to cover as required. Wards used the same bank staff if possible to maintain continuity and ensure that the staff and patients were familiar with each other and booked staff for long periods in advance to ensure continuity.
- Locum agency staff received the same induction and mandatory training as permanent members of staff and had the same access to electronic record systems.
- On each ward there were enough staff on duty to allow patients to have regular one to one time with their named nurse. Staff rarely cancelled escorted leave due to staff shortages.

Medical staff

- Each ward had adequate medical cover. The hospital operated an on call system so there was always a doctor available who could attend the hospital quickly in an emergency. The hospital employed a locum doctor through an agency who had accommodation within the hospital grounds so was available as a first point of call.
- Medical cover was also provided by a GP who attended the hospital weekly. All patients in the long term secure wards were registered at this GP's practice. The hospital had service level agreements with local specialist services such as tissue viability and dentistry. The GP could refer to specialist medical services including speech and language therapists or continence specialists. The hospital had an immediate life support response team available at all times to address any medical emergencies.
- Each ward had a dedicated consultant psychiatrist to provide seclusion reviews, complete patient admissions and respond to psychiatric emergencies.

Mandatory training

- All staff mandatory training was up to date across all wards. Staff were given protected time to complete mandatory training if necessary to ensure they remained compliant. The hospital had a robust system in place to ensure that staff were notified whenever any mandatory training was due to expire.
- Examples of mandatory training included immediate life support, equality, diversity and human rights, Mental Health Act and Code of Practice, and safeguarding adults and children.
- The hospital used locum nurses who were able to access the same training as permanent staff members. If a bank or locum staff member did not have full mandatory training compliance they would not be able to work on the wards until this had been completed.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed 20 risk assessments across three wards. These were detailed and covered historic and current risk indicators.
- Staff completed a risk assessment of each patient on admission. Staff updated these following incidents and at regular intervals to ensure they remained up to date.

- Staff used the historical, clinical risk management -20 tool which provided a comprehensive risk history and current risk. Risk assessments were thorough and detailed throughout.

Management of patient risk

- Staff followed ward policies on searching patients and their property on return to the ward from any leave. The hospital had a list of prohibited items at the front reception desk so patients knew what they were allowed and not allowed on the ward. Patients were made aware of the search policy as part of their admission pack and orientation to the ward.
- Staff followed appropriate observation policies. If staff felt a patient required additional levels of observation then the nurse in charge could increase the level, and request additional staff if any additional one to one observations were needed. The decision to reduce a patient's observation levels were taken by a full multidisciplinary team to ensure all staff had input and all risks were considered.
- The hospital was a smoke free site. Staff managed this by use of escorted leave for patients and the promotion of smoking cessation groups and support.

Use of restrictive interventions

- In the period from February – April 2018 there were 11 episodes of seclusion across the three wards we visited. These were highest in Helen Keller ward which reported seven episodes of seclusion. Five of these seclusion episodes included the use of rapid tranquilisation, again the highest number being on Helen Keller ward using rapid tranquilisation on three occasions. We saw evidence which showed staff had followed appropriate procedures after seclusion in terms of patient observation and de-brief.
- In the period from February – April 2018 there were 37 episodes of restraint across the three wards we visited. The highest number of restraints took place on Helen Keller ward with 21 restraints. Staff we spoke with understood the rationale for restraint and stated that this was used only when all other forms of de-escalation had been tried.
- Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation and we saw evidence of patient monitoring following rapid tranquilisation.
- We reviewed three seclusion records. One record showed that the paper record did not match what was recorded on the electronic care notes. This could be confusing and was not clear what had happened. Also the paper notes were incomplete making it unclear when the seclusion ended and the rationale for this. We raised this with the hospital at the time of the inspection and received assurances that managers of each ward would raise this issue at team meetings and in individual staff supervision.

Safeguarding

- All staff had received training in safeguarding and were aware of how to make a safeguarding alert to the local authority. The hospital had good links with the local authority and employed a social worker who provided a link between the wards and the local authority.
- Staff we spoke with could give examples of when they would raise a safeguarding concern, including patient aggression, discrimination or potential exploitation. Staff were aware of which patients were on the ward with protected characteristics under the Equality Act.
- Each ward followed safe procedures and ward policies on children visiting their relatives in hospital. Children did not go on to the ward, but the hospital had rooms off the ward for patients to see their children. Staff would supervise these visits where appropriate.

Staff access to essential information

- Staff recorded all patient information on the hospital electronic recording system. This was available to all permanent staff and locum agency staff, however this was not immediately available to agency staff when they came on to the ward. This meant that agency staff were reliant on receiving updates and information from permanent staff to ensure they were up to date. Agency staff were also not able to record on the electronic system which meant that only permanent or locum staff could input updates on to patient records.

Medicines management

- Staff completed daily national early warning signs observations on all patients, unless they refused. National early warning signs observations are a scoring system used by NHS and independent hospitals to monitor patients' physical health. The scores are based on six tests: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse and level of

consciousness. Each test provides a score which nursing staff can use to determine when next the tests should be completed. Staff recorded if a patient declined to have their observations recorded. However, we did see evidence that on Michael Shepherd ward staff did not always follow the protocol to re-test within four hours if the score indicated this. Staff were completing the checks daily regardless of whether the score indicated a more frequent test was needed. We raised this with the hospital managers at the time of the inspection who provided assurances that this would be raised at team meetings and in individual supervisions to ensure all staff were aware of the process for re-testing if scores indicated this was needed.

- Staff followed good practice in medicines management and each ward had good links and access to the local pharmacy. The local pharmacy provided a real time interactive service so staff could log on daily to update any medicines orders they needed. All medicines stored in clinic rooms were checked daily and disposed appropriately when required.

Track record on safety

Reporting incidents and learning from when things go wrong

- All staff were aware of the incident reporting process. Staff reported incidents on the hospital electronic incident recording system and knew what to report. Managers within the hospital then reviewed incidents in line with their managing incidents and untoward occurrences policy. This policy ensured that ongoing lessons could be learnt before the conclusion of the investigation. When the investigation was concluded formal lessons were shared across the hospital via the multidisciplinary team meeting and ward team meetings. Learning was also emailed to all members of staff to ensure everyone had the opportunity to learn from incidents.
- Staff involved patients in any debrief to see how the incident was experienced from a patient perspective. The hospital had a duty of candour policy and was open and transparent in sharing with the patient when errors had been made.
- Managers from the senior management team discussed any incidents at the daily multidisciplinary team meeting. All ward managers and managers from each department attended this meeting, for example social work or psychology. The managers then fed back any updates on incidents and learning to their own teams by e-mail and team meetings. This ensured that lessons were shared across the hospital and did not stay within the ward where the incident happened.
- Some staff did report that they were not always aware of any actions that had been taken as a result of incidents which demonstrated the learning at management level did not always reach staff on the wards. We raised this with the managers at the time of the inspection who gave us assurances that the process of cascading information from managers to all staff would be reviewed and made more robust.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

At the last comprehensive inspection in October 2016 we rated effective as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Kindness, privacy, dignity, respect, compassion and support

- We observed numerous positive interactions between staff and patients. Staff demonstrated a good knowledge and understanding of the patients they were caring for and treated them kindly and with respect.
- Staff demonstrated a good knowledge and awareness of individual patient needs including their personal, cultural social and religious needs.
- Patients reported that staff treated them well and that they felt safe and well looked after. We observed staff behaving appropriately towards patients at all times.
- Patients we spoke with told us that staff gave them information about the treatment they were receiving to help them understand and better manage their

condition. There were information leaflets on the wards with details of various mental health conditions and medicines used to treat them. These were available for patients to use to better understand their condition.
- Staff maintained patient confidentiality and patients reported that staff always knocked before entering their bedroom.
- Staff reported being able to raise concerns about any disrespectful or abusive behaviour without the fear of any consequences.

Involvement in care

Involvement of patients

- We reviewed 20 care records. These showed inconsistencies in patient involvement in their own care planning. Patients reported being involved, but said they did not have copies of their care plan. We did not see recorded evidence that patients had copies of their care plans. We raised this with managers at the time of the inspection who provided assurances that this would be monitored more closely at the daily morning handover meeting and managers would use individual supervision and team meetings to reinforce the need for patients to have a copy of their own care plan.
- Staff did not always demonstrate understanding of providing information to patients in different formats, such as easy read, if this was required.
- Each ward had a weekly community meeting for patients to give feedback on the service they were receiving and make suggestions. We reviewed the minutes of these meetings which showed evidence of how the wards had listened to patients and implemented changes where appropriate. The wards also had 'you said, we did' boards to highlight areas where changes had been made as a result of patient feedback.
- Patients had access to advocacy on all wards and we saw poster and leaflets advertising the local advocacy service.

Involvement of families and carers

- Families and carers were invited to patient care programme approach meetings to provide input into any care decisions. Staff advised families and carers well in advance of any decisions regarding potential discharge or hospital transfer to allow them to be fully involved in the process.
- Staff gave families and carers the opportunity to give feedback on the service by way of surveys and discharge questionnaires.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

At the last comprehensive inspection in October 2016 we rated responsive as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

At the last comprehensive inspection in October 2016 we rated well led as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Forensic inpatient/secure wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are forensic inpatient/secure wards safe?

Safe and clean environment

Safety of the ward environment

- Each ward had a security lead for each shift who was responsible for environmental security on that shift. This included ensuring patient observations were completed, cutlery was counted before and after each mealtime, checking the ward for any prohibited items and the overall security of the ward. This role was carried out by trained healthcare assistants to ensure an appropriate member of staff undertook this role.
- There were blind spots on each of the wards, although this was managed by use of staff observation and the use of convex mirrors. Each ward had a blind spot risk assessment to identify areas of risk and each had an accompanying action plan to mitigate identified risks.
- Staff had identified any ligature anchor point risks and these were documented on each ward in a comprehensive ligature risk audit that had recently been completed. This contained actions to mitigate any identified risks.
- Each ward was single sex and so complied with Department of Health guidance on single sex accommodation. All patient bedrooms had ensuite shower rooms.
- Staff carried alarms at all times which they signed in and out from the hospital reception at the start and end of each shift. Staff also had their own keys which they signed for at the beginning of their shift and returned when they left. The nurse in charge of each shift also carried the medicine keys to ensure that these were safe and no patients could enter the clinic room or access medicines unsupervised.

Maintenance, cleanliness and infection control

- All wards were clean, spacious and well maintained. Each ward had quiet rooms and spaces for patients to use which were clean and had suitable furnishings.
- Cleaning records showed that the ward was cleaned regularly and cleaning records were up to date.
- Staff adhered to infection control principles and we saw hand gel dispensers outside each ward and in the reception area for staff and visitors to use prior to going on to the ward.

Seclusion room

- The seclusion room on Elizabeth Anderson ward was well designed and equipped. There was a visible clock, observation panels and hatch at a suitable height and a shower and toilet facilities.
- The seclusion room on Michael Shepherd ward was adequate, but the hatch was low in the door making it difficult to use and posed a risk of patients getting their arm through when this was opened. However, there was a clock and appropriate shower and toilet facilities.
- The seclusion room for Michael Shepherd was not located on the ward, which meant that staff had to accompany patients off the ward to take them to seclusion. This could potentially cause issues of patient safety and leave the ward short staffed whilst the patient was transferred.

Clinic room and equipment

- Clinic rooms on each ward were well stocked and had accessible resuscitation equipment that was checked regularly. Staff checked medicines and equipment regularly and monitored fridge temperatures daily.

Safe staffing

Nursing staff

- Staffing levels could be adjusted on each ward depending on the number of patients on the ward, and the amount of one-to-one patient observations. The

wards had a staffing ladder which showed the minimum number of staff required on shift. For each patient on one-to-one observations the ward manager could request an additional healthcare assistant so that the staff member completing observations would not be taken from the shift numbers.

- Each ward had a minimum of two qualified nursing staff on each day shift and one at night. There was a night shift and day shift nurse co-ordinator for the hospital as a whole each day who could arrange for cover and additional staff if required.
- Staff worked a shift pattern of 7.30am – 8pm, and 7.30pm – 8am. There was always a minimum of two qualified nurses on each day shift and one for each night shift. The management team held a multidisciplinary team meeting every morning at which staffing levels for the hospital were discussed. If a ward was under staffed, staff could be moved from another ward to cover if that did not leave a ward short.
- Each ward had staff vacancies. Elizabeth Anderson ward had seven nurse vacancies and 11 healthcare assistant vacancies; Michael Shepherd ward had three nurse vacancies and nine healthcare assistant vacancies and Helen Keller ward had six nurse vacancies and 11 healthcare assistant vacancies. The hospital was proactively recruiting to these vacancies and could offer interviews to potential staff at short notice.
- Despite the high level of staff vacancies we saw rotas which showed shifts were covered and the wards were not under-staffed. All shifts were covered with each ward using regular agency locum staff to cover as required. Wards used the same bank staff if possible to maintain continuity and ensure that the staff and patients were familiar with each other and booked staff for long periods in advance to ensure continuity.
- Locum agency staff received the same induction and mandatory training as permanent members of staff and had the same access to electronic record systems.
- On each ward there were enough staff on duty to allow patients to have regular one to one time with their named nurse. Staff rarely cancelled escorted leave due to staff shortages.

Medical staff

- Each ward had adequate medical cover. The hospital operated an on call system so there was always a doctor available who could attend the hospital quickly in an emergency. The hospital employed a locum doctor through an agency who had accommodation within the hospital grounds so was available as a first point of call.
- Medical cover was also provided by a GP who attended the hospital weekly. All patients in the long term secure wards were registered at this GP's practice. The hospital had service level agreements with local specialist services such as tissue viability and dentistry. The GP could refer to specialist medical services including speech and language therapists or continence specialists. The hospital had an immediate life support response team available at all times to address any medical emergencies.
- Each ward had a dedicated consultant psychiatrist to provide seclusion reviews, complete patient admissions and respond to psychiatric emergencies.

Mandatory training

- All staff mandatory training was up to date across all wards. Staff were given protected time to complete mandatory training if necessary to ensure they remained compliant. The hospital had a robust system in place to ensure that staff were notified whenever any mandatory training was due to expire.
- Examples of mandatory training included immediate life support, equality, diversity and human rights, Mental Health Act and Code of Practice, and safeguarding adults and children.
- The hospital used locum nurses who were able to access the same training as permanent staff members. If a bank or locum staff member did not have full mandatory training compliance they would not be able to work on the wards until this had been completed.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed 20 risk assessments across three wards. These were detailed and covered historic and current risk indicators.
- Staff completed a risk assessment of each patient on admission. Staff updated these following incidents and at regular intervals to ensure they remained up to date.
- Staff used the historical, clinical risk management -20 tool which provided a comprehensive risk history and current risk. Risk assessments were thorough and detailed throughout.

Forensic inpatient/secure wards

Management of patient risk

- Staff followed ward policies on searching patients and their property on return to the ward from any leave. The hospital had a list of prohibited items at the front reception desk so patients knew what they were allowed and not allowed on the ward. Patients were made aware of the search policy as part of their admission pack and orientation to the ward.
- Staff followed appropriate observation policies. If staff felt a patient required additional levels of observation then the nurse in charge could increase the level, and request additional staff if any additional one to one observations were needed. The decision to reduce a patient's observation levels were taken by a full multidisciplinary team to ensure all staff had input and all risks were considered.
- The hospital was a smoke free site. Staff managed this by use of escorted leave for patients and the promotion of smoking cessation groups and support.

Use of restrictive interventions

- In the period from February – April 2018 there were 11 episodes of seclusion across the three wards we visited. These were highest in Helen Keller ward which reported seven episodes of seclusion. Five of these seclusion episodes included the use of rapid tranquilisation, again the highest number being on Helen Keller ward using rapid tranquilisation on three occasions. We saw evidence which showed staff had followed appropriate procedures after seclusion in terms of patient observation and de-brief.
- In the period from February – April 2018 there were 37 episodes of restraint across the three wards we visited. The highest number of restraints took place on Helen Keller ward with 21 restraints. Staff we spoke with understood the rationale for restraint and stated that this was used only when all other forms of de-escalation had been tried.
- Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation and we saw evidence of patient monitoring following rapid tranquilisation.
- We reviewed three seclusion records. One record showed that the paper record did not match what was recorded on the electronic care notes. This could be confusing and was not clear what had happened. Also the paper notes were incomplete making it unclear when the seclusion ended and the rationale for this. We raised this with the hospital at the time of the inspection and received assurances that managers of each ward would raise this issue at team meetings and in individual staff supervision.

Safeguarding

- All staff had received training in safeguarding and were aware of how to make a safeguarding alert to the local authority. The hospital had good links with the local authority and employed a social worker who provided a link between the wards and the local authority.
- Staff we spoke with could give examples of when they would raise a safeguarding concern, including patient aggression, discrimination or potential exploitation. Staff were aware of which patients were on the ward with protected characteristics under the Equality Act.
- Each ward followed safe procedures and ward policies on children visiting their relatives in hospital. Children did not go on to the ward, but the hospital had rooms off the ward for patients to see their children. Staff would supervise these visits where appropriate.

Staff access to essential information

- Staff recorded all patient information on the hospital electronic recording system. This was available to all permanent staff and locum agency staff, however this was not immediately available to agency staff when they came on to the ward. This meant that agency staff were reliant on receiving updates and information from permanent staff to ensure they were up to date. Agency staff were also not able to record on the electronic system which meant that only permanent or locum staff could input updates on to patient records.

Medicines management

- Staff completed daily national early warning signs observations on all patients, unless they refused. National early warning signs observations are a scoring system used by NHS and independent hospitals to monitor patients' physical health. The scores are based on six tests: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse and level of consciousness. Each test provides a score which nursing staff can use to determine when next the tests should be completed. Staff recorded if a patient declined to have their observations recorded. However, we did see evidence that on Michael Shepherd ward staff did not

always follow the protocol to re-test within four hours if the score indicated this. Staff were completing the checks daily regardless of whether the score indicated a more frequent test was needed. We raised this with the hospital managers at the time of the inspection who provided assurances that this would be raised at team meetings and in individual supervisions to ensure all staff were aware of the process for re-testing if scores indicated this was needed.

- Staff followed good practice in medicines management and each ward had good links and access to the local pharmacy. The local pharmacy provided a real time interactive service so staff could log on daily to update any medicines orders they needed. All medicines stored in clinic rooms were checked daily and disposed appropriately when required.

Track record on safety

Reporting incidents and learning from when things go wrong

- All staff were aware of the incident reporting process. Staff reported incidents on the hospital electronic incident recording system and knew what to report. Managers within the hospital then reviewed incidents in line with their managing incidents and untoward occurrences policy. This policy ensured that ongoing lessons could be learnt before the conclusion of the investigation. When the investigation was concluded formal lessons were shared across the hospital via the multidisciplinary team meeting and ward team meetings. Learning was also emailed to all members of staff to ensure everyone had the opportunity to learn from incidents.
- Staff involved patients in any debrief to see how the incident was experienced from a patient perspective. The hospital had a duty of candour policy and was open and transparent in sharing with the patient when errors had been made.
- Managers from the senior management team discussed any incidents at the daily multidisciplinary team meeting. All ward managers and managers from each department attended this meeting, for example social work or psychology. The managers then fed back any updates on incidents and learning to their own teams by e-mail and team meetings. This ensured that lessons were shared across the hospital and did not stay within the ward where the incident happened.
- Some staff did report that they were not always aware of any actions that had been taken as a result of incidents which demonstrated the learning at management level did not always reach staff on the wards. We raised this with the managers at the time of the inspection who gave us assurances that the process of cascading information from managers to all staff would be reviewed and made more robust.

Are forensic inpatient/secure wards effective?
(for example, treatment is effective)

At the last comprehensive inspection in October 2016 we rated effective as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are forensic inpatient/secure wards caring?

Kindness, privacy, dignity, respect, compassion and support

- We observed numerous positive interactions between staff and patients. Staff demonstrated a good knowledge and understanding of the patients they were caring for and treated them kindly and with respect.
- Staff demonstrated a good knowledge and awareness of individual patient needs including their personal, cultural social and religious needs.
- Patients reported that staff treated them well and that they felt safe and well looked after. We observed staff behaving appropriately towards patients at all times.
- Patients we spoke with told us that staff gave them information about the treatment they were receiving to help them understand and better manage their condition. There were information leaflets on the wards with details of various mental health conditions and medicines used to treat them. These were available for patients to use to better understand their condition.
- Staff maintained patient confidentiality and patients reported that staff always knocked before entering their bedroom.
- Staff reported being able to raise concerns about any disrespectful or abusive behaviour without the fear of any consequences.

Forensic inpatient/secure wards

Involvement in care

Involvement of patients

- We reviewed 20 care records. These showed inconsistencies in patient involvement in their own care planning. Patients reported being involved, but said they did not have copies of their care plan. We did not see recorded evidence that patients had copies of their care plans. We raised this with managers at the time of the inspection who provided assurances that this would be monitored more closely at the daily morning handover meeting and managers would use individual supervision and team meetings to reinforce the need for patients to have a copy of their own care plan.
- Staff did not always demonstrate understanding of providing information to patients in different formats, such as easy read, if this was required.
- Each ward had a weekly community meeting for patients to give feedback on the service they were receiving and make suggestions. We reviewed the minutes of these meetings which showed evidence of how the wards had listened to patients and implemented changes where appropriate. The wards also had 'you said, we did' boards to highlight areas where changes had been made as a result of patient feedback.
- Patients had access to advocacy on all wards and we saw poster and leaflets advertising the local advocacy service.

Involvement of families and carers

- Families and carers were invited to patient care programme approach meetings to provide input into any care decisions. Staff advised families and carers well in advance of any decisions regarding potential discharge or hospital transfer to allow them to be fully involved in the process.
- Staff gave families and carers the opportunity to give feedback on the service by way of surveys and discharge questionnaires.

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

At the last comprehensive inspection in October 2016 we rated responsive as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are forensic inpatient/secure wards well-led?

At the last comprehensive inspection in October 2016 we rated well led as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all seclusion paperwork is completed fully and that the paper record corresponds to the appropriate electronic record
- The provider should ensure that any physical health checks are followed up within appropriate timescales
- The provider should ensure that all staff are aware of any learning from incidents and that decisions made at management level are shared across the whole care team.
- The provider should ensure that all patients who wish to have a copy of their care plan have one.