Good

Greater Manchester West Mental Health NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXV00	Greater Manchester West Mental Health NHS Foundation Trust – HQ	Borrowdale Ward, Buttermere Ward, Coniston Ward, Derwent Ward, Dovedale Ward, Eskdale Ward, Ferndale Ward, Hayswater Ward, Keswick Ward, Isherwood ward, Delaney Ward, Lowswater Ward, Newlands Ward, Rockley House, Rydal Ward, Silverdale Ward, Ullswater Ward	M25 3BL
RXV20	Wentworth House	Wentworth House	M30 9HF

This report describes our judgement of the quality of care provided within this core service by Greater Manchester West Mental Health NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Greater Manchester West Mental Health NHS Foundation Trust and these are brought together to inform our overall judgement of Greater Manchester West Mental Health NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated forensic inpatient/secure wards as **good** because:

- Care and treatment was provided by a multidisciplinary team of staff, which included doctors, nurses and healthcare assistants, occupational therapists, psychologists, social workers and pharmacy.
- Patients were assessed and care plans were developed. Staff understood patients' needs.
- The findings of the friends and family test showed that people were generally satisfied, except for the availability of activities. Patients were mostly positive about the staff. Patients felt involved in their care plans, but there was limited evidence of this in the records.
- Patients were involved in decisions about the service, which included the recruitment process and the recovery academy. There were regular community meetings where patients could give their views of problems or developments in the service.
- The service routinely reviewed its use of restrictions on patients. This was balanced against the need for security procedures to keep patients and others safe.
- The service provided 25 hours of activity to patients per week, and monitored this target. Patients had access to the Patterdale Centre, which provided activities such as a gym and bike riding. The Edenfield Centre had a branch of the recovery academy, which provided therapy and activity groups, some of which were co-produced with patients. Work opportunities were provided for patient, which included painting and decorating, and car valeting.
- The service used the trust-wide governance structures for monitoring the quality of care and of the service. This included reporting incidents, feedback about complaints, safeguarding and staffing. Ward managers monitored and took action on key performance indicators. These included staffing levels, training, supervision, if recovery care plans were in place, and activities.
- The trust had initiatives where managers could apply for one-off funding to improve their service. This had been used to install a Zen garden, and a new patients' kitchen.
- The wards had environmental risks, but staff managed these and there was an ongoing programme of refurbishment to remove them. The wards were clean and maintained.
- Staffing levels were monitored, and recruitment was ongoing. There was pressure on staff, but leave and activities were rarely cancelled because there was not enough staff. Staff received regular supervision, training and appraisal.
- Medication was stored correctly.

However:

- Not all the care plans were patient-centred or recovery focused. There was a new electronic records system, and many staff found it difficult to use or find information in it.
- Training in the Mental Health Act and the Mental Capacity Act was limited. There were errors on consent to treatment forms under the Mental Health Act.
- Although staff explained patients' rights under the Mental Health Act and requested support from independent mental health advocates appropriately, staff did not consistently record this information in individual patient care records.
- Not all eligible staff across the wards we visited had completed mandatory training in basic life support and intensive life support.
- When staff administered rapid tranquilisation, physical health checks were not always completed consistently afterwards which may put patients at risk.
- Staff had not always completed medication records correctly, and there were gaps in charts. There was a process for reporting and learning from medication errors, and nurses worked through a competency process to ensure they were safe to practice.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- When staff administered rapid tranquilisation, physical health checks were not always completed afterwards which may put patients at risk.
- Risk assessments did not always include changes in risks, and care plans did not always reflect the assessment.
- Medication records were not always completed correctly.
- Not all eligible staff had completed mandatory training in basic life support and immediate life support. This placed patients at risk because there were not enough staff to perform life support techniques in an emergency.

However:

- Seclusion facilities were in keeping with the Mental Health Act code of practice. When patients were secluded, the four-hourly checks were often completed by an advanced practitioner (a senior nurse) and not a doctor – this was often at night, but also during the day.
- Recognised assessment tools were used to assess each patient's level of risk.
- The wards had environmental risks, but these were managed by staff and there was an ongoing programme of refurbishment to remove them.
- The wards were clean and maintained.
- Medication was stored correctly.
- There was a process for reporting and learning from medication errors, and nurses worked through a competency process to ensure they were safe to practice.
- Staffing levels were monitored, and recruitment was ongoing. There was pressure on staff, but leave and activities were rarely cancelled because there were not enough staff.
- Most staff had completed most of their mandatory training.
- Staff received information about deescalating potentially violent or aggressive behaviour.
- The service routinely reviewed its use of restrictions on patients. This was balanced against the need for security procedures to keep patients and others safe.

Are services effective?

Good

We rated effective as **good** because:

Summary of findings

- Care and treatment was provided by a multidisciplinary team of staff which included doctors, nurses and healthcare assistants, occupational therapists, psychologists, social workers and pharmacy.
- Patients had access to psychological therapies and the recovery academy.
- The service provided physical healthcare clinics, and patients' physical healthcare was monitored.
- Staff received regular supervision, training and appraisal.
- Patients were assessed and care plans were developed. Staff understood patients' needs.
- Patients told us that staff read explained their rights under the Mental Health Act.
- Independent Mental Health Advocates also visited all the wards twice a week to support patients who were detained under the Mental Health Act.

However:

- Training in the Mental Health Act and the Mental Capacity Act was limited, and there were errors on consent to treatment forms under the Mental Health Act.
- Not all the care plans were patient-centred or recovery focused.
- There was a new electronic records system, and many staff found it difficult to use or find information in it.

Are services caring?

Good

We rated caring as **good** because:

- Patients were mostly positive about the staff.
- Patients felt involved in their care plans.
- Patients were involved in decisions about the service, which included the recruitment process and the recovery academy.
- There were regular community meetings where patients could give their views of problems or developments in the service.
- The findings of the friends and family test showed that people were generally satisfied, except for the availability of activities.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- The wards had clinic rooms, activity rooms, quiet rooms and outdoor space.
- The service provided 25 hours of activity to patients per week, and monitored this target.

Summary of findings

- Patients had access to the Patterdale Centre, which provided activities such as a gym and bike riding. The Edenfield Centre had a branch of the recovery academy, which provided therapy and activity groups, some of which were co-produced with patients.
- A national charity provided work opportunities and qualifications and credit frameworks NVQ qualifications for patients. This included painting and decorating, and car valeting.
- All the wards had access to a multi-faith room and chaplaincy service.
- Patients were only transferred to another ward as part of their care pathway or if there were difficulties between patients.

Are services well-led?

Good

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

- Staff were aware of the vision and values of the trust.
- The service used the trust-wide governance structures for monitoring the quality of care and of the service. This included reporting incidents, feedback about complaints, safeguarding and staffing.
- Ward managers monitored and took action on key performance indicators. These included staffing levels, training, supervision, if recovery care plans were in place, and activities.
- The trust had a “dragons’ den” initiative, where managers could apply for one-off funding to improve their service. This had been used to install a Zen garden, and a new patients’ kitchen.

Summary of findings

Information about the service

The forensic inpatient/secure wards provided by Greater Manchester West Mental Health NHS Foundation Trust are part of the trust's specialist services network.

There are 18 wards. Sixteen of the wards are on the Prestwich Hospital site: 12 wards are in the Edenfield Centre (Rydal, Dovedale, Eskdale, Borrowdale, Silverdale, Coniston, Ullswater, Keswick, Ferndale, Buttermere, Derwent, and Hayeswater); two wards are in the Lowry Unit (Isherwood and Delaney); and Loweswater and Newlands are standalone units. Rockley House is in a residential area of Prestwich, and Wentworth House is in Eccles.

Medium secure services for men are provided at:

- Assessment: Rydal ward (15 beds), Dovedale ward (15 beds), Eskdale ward (13 beds);
- Ongoing treatment: Borrowdale ward (17 beds), Silverdale ward (16 beds), Coniston ward (15 beds);
- Pre-discharge: Ullswater ward (18 beds), Keswick ward (18 beds);
- Long term: Ferndale ward (15 beds).

Medium secure services for women are provided on:

- Assessment: Buttermere ward (9 beds);
- Ongoing treatment: Derwent ward (5 beds);
- Enhanced support: Hayeswater ward (4 beds).

Secure open rehabilitation or step down from medium secure services are provided at:

- Newlands (8 male beds);
- Rockley House (6 male beds);
- Wentworth House (10 female beds).

Low secure services are provided at:

- Isherwood ward (15 male beds);
- Delaney ward (15 male beds);
- Loweswater (12 female beds).

There have been 18 previous inspections across seven locations registered to Greater Manchester West Mental Health NHS Foundation Trust. At the time of the last inspection, none of the locations were non-compliant.

Our inspection team

The team was led by:

Chair: Dr Peter Jarrett

Head of Inspection: Nick Smith, Care Quality Commission

Team Leader: Sarah Dunnett, Inspection Manager, Care Quality Commission

The team that inspected the service comprised a CQC inspection manager, two CQC inspectors. a Mental Health Act reviewer, two CQC pharmacy inspectors, an expert by experience, two consultant forensic psychiatrists, three nurses and an occupational therapist.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients and staff at focus groups.

During the inspection visit, the inspection team:

- Visited all 18 of the wards at the main Prestwich site, and at other sites in Prestwich and Eccles. We looked at the quality of the ward environments and observed how staff were caring for patients;
- spoke with 49 patients and collected feedback from 98 patients using comment cards;
- spoke with six carers or relatives of patients;
- spoke with the managers or acting managers for each of the wards;
- spoke with 64 other staff members including doctors, nurses, psychologists and occupational therapists;
- attended and observed five multi-disciplinary meetings, attended an activity group, and visited the Recovery Academy in the Edenfield Centre;
- looked at 81 care and treatment records of patients;
- looked at 132 prescription charts of patients;
- carried out a specific check of the medication management on four wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- We spoke with 49 patients and six carers or relatives of patients. We collected feedback from 98 patients using comment cards.
- Patients told us that they were treated with respect by staff, and patients found most staff supportive. Most of the patients we spoke with were positive about the service they received.
- Most of the patients we spoke with felt involved in their care planning, even though they may not agree with the treatment plan. Patients were offered a copy of their care plan.
- The specialist services network provided a family, friends and parents' information pack for carers. The carers we spoke with were positive about the service. There were facilities for families to visit their relatives in the hospital.
- Patients and carers answered the "friends and family test" by using electronic terminals placed around the trust. During October to December 2015, 216 patient responses were recorded in adult forensic services. Most answers scored above 85% (areas of strength) or from 75%-85% (areas for improvement). Most patients responded that staff treated them with respect and they were listened to. The service had worse results when patients were asked about activities: 31% of low secure respondents and 43% of medium secure respondents thought the activities available were fair or poor.
- The wards had regular, usually weekly, community meetings where patients and staff could discuss suggestions for or problems on the ward.
- Patients were involved in decisions about the service. For example, patients were involved in the recruitment process, and supported staff to run sessions in the trust's recovery academy.

Summary of findings

Good practice

- The trust had a recovery academy that provided training and courses for staff and patients. The Edenfield Centre had its own branch of the recovery academy specifically for patients on the forensic inpatient wards. The recovery academy provided groups and sessions for patients. Patients were involved in the creation and provision of some of the groups. They included living with a personality disorder, peer mentoring (where patients supported other patients), and a pre-discharge course. This was for patients who may have been in hospital for a long time, and addressed practical issues such as how to register with a GP.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff monitor patients' physical healthcare after medication had been given for rapid tranquilisation, so that any side effects are identified.
- The trust must ensure that staff have the skills and experience to provide care to patients in the event of a medical emergency.

Action the provider SHOULD take to improve

- The trust should keep its environmental risks under review;
- The trust should ensure its auditing of medication procedures, and competency training are effective;
- The trust should continue to improve the usability of the electronic record system;
- The trust should ensure that consent to treatment forms (T2s and T3s) are completed correctly;
- The trust should ensure that where patients have their rights explained under the Mental Health Act, this is recorded in individual patient care records;
- The trust should continue to improve the usability of the electronic record system;
- The trust should ensure that staff have appropriate knowledge and understanding of the Mental Health Act and the Mental Capacity Act;
- The trust should ensure that all risk assessments and care plans are up to date, person centred, recovery focused and reflect the care needs of each patient.

Greater Manchester West Mental Health NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Borrowdale Ward, Buttermere Ward, Coniston Ward, Derwent Ward, Dovedale Ward, Eskdale Ward, Ferndale Ward, Hayswater Ward, Keswick Ward, Isherwood ward, Delaney Ward, Lowswater Ward, Newlands Ward, Rockley House, Rydal Ward, Silverdale Ward, Ullswater Ward	Greater Manchester West Mental Health NHS Foundation Trust – HQ
Wentworth House	Wentworth House

Mental Health Act responsibilities

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

- Patients using the service were usually detained under the MHA.
- Training in the MHA was not part of the trust's mandatory training programme, and low numbers of staff had received up to date training. However, the trust had recently implemented an elearning package.
- On eight of the wards, there were consent to treatment forms that did not accurately reflect the medication the patient was prescribed, or were out of date. This meant that nursing staff had administered medication to patients without a valid MHA authority. These issues were raised with the managers of each of the wards.
- Patients had their rights under the MHA explained to them when they were admitted to the service, when they were transferred to another ward, or if there was a change in their status. Staff also explained patients their rights under the MHA at least once every three months

thereafter, however, some patients were not willing to engage in this discussion. Furthermore, staff did not always document where discussions had taken place in individual patient care records.

- The trust had MHA policies, and staff were supported in its implementation by the MHA administration team.
- Patients had access to independent MHA advocates (IMHAs). IMHAs visited all the wards at least once a week to support patients who were detained under the MHA. This included attending individual patient care reviews with the multi-disciplinary team.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There were no patients subject to the Deprivation of Liberty Safeguards (DoLS), and no applications had been made in the last six months. Patients using the service were almost always detained under the Mental Health Act.
- Training in the Mental Capacity Act (MCA) and DoLS was not part of the trust's mandatory training programme, and low numbers of staff had received up to date training.
- Staff understanding of the MCA and DoLS was variable. Care records included evidence of informed consent, but not always an assessment of capacity. It was not clear if this was due to the information not being recorded in the trust's new electronic record system.
- Patients had their capacity assessed with regards to whether they could make decisions, for example, about their finances or physical health. Where patients had been deemed to lack the capacity to make a decision then action had been taken in their best interest.

CQC have made a public commitment to reviewing provider adherence to MCA and DoLS.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- Staff completed environmental risk assessments for each of the wards. These identified and rated risks, which included ligatures, across all the forensic inpatient services. The wards were of different ages and stages of refurbishment. Patients' bedrooms had ligature free fittings. There were blind spots and ligatures in communal areas of some of the wards. The windows in many of the wards had been identified as a ligature risk. The trust planned to refurbish all the windows to reduce or remove the ligature risk, and had a prioritised programme of work to do this across the service. The existing risks were managed by risk assessing patients, and regular observation on the wards.
- The hospital complied with guidance on same-sex accommodation. All wards were single sex.
- All the wards had a fully equipped clinic room. Each ward had resuscitation equipment and emergency medication. These were routinely checked and tagged by the facilities department, pharmacy and nursing staff.
- A CQC Mental Health Act reviewer carried out a review of the seclusion facilities in the Edenfield Centre in August 2015. This identified areas that needed to be addressed. These were reviewed at this inspection, and had been resolved. The seclusion room on Loweswater ward was consistent with guidance in the Mental Health Act code of practice. It allowed clear observation, had two-way communication, toilet and shower facilities, and a clock. Heat, light and the external window blind were controlled from outside the room. It was in a corridor separate from the main ward, and was accessible through a separate entrance.
- All the wards were clean and adequately maintained. Some of the wards, such as Eskdale, Delany and Isherwood, were new buildings and all the patients had ensuite facilities, and the wards were modern. Other wards, such as Ullswater and Coniston, were older and had a planned programme of refurbishment. The bedrooms on Ullswater ward were not ensuite, and the bathrooms were worn. All the bedrooms were single, but some had been converted from dormitories and were small and narrow.
- Infection control and handwashing audits were carried out. There were handwashing sinks on all the wards, and appropriate supplies of gloves in the clinic rooms.
- Staff carried emergency alarms. The response team at the Edenfield Centre was coordinated by a duty nurse, who was a team leader or ward manager. A member of staff trained in the prevention and management of violence (PMVA) was allocated to respond from each ward. Staff confirmed that when an alarm was activated up to 13 staff could respond to the incident. Staff outside the Edenfield Centre had different arrangements. Staff at Loweswater, approximately a mile away from the Edenfield Centre, had alarms that sounded within the unit, or telephoned the Prestwich site emergency number for assistance. This was a new system, but staff told us it had worked effectively on the only occasion they had needed it so far.

Safe staffing

- Information provided by the trust showed that up to 31 December 2015, 391 staff were employed by the forensic inpatient services. There was a 13% vacancy rate, which consisted of 28 qualified nurses and 32 healthcare assistants. The percentage of staff sickness was 6%, which is above the trust average of 5%. Seventy staff had left, which gave a staff turnover of 18%.
- There was an electronic rostering system used on all the wards. The medium secure wards had adopted a new system, which it was planned to roll out to the low secure wards in the future. Both tools supported staff to monitor staff levels, and this was reported and monitored centrally within the trust.
- Ward managers were clear about their vacancy rate, and action that had been taken to recruit and retain staff. The step-down/pre-discharge wards had low levels of violence and aggression. As such, staff that were injured or pregnant were moved to work on these wards. This resulted in a changing staff team, and fluctuations in vacancy rates.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Ward managers had flexibility with their staffing levels, and were able to make adjustments to take account of ward activity. All ward managers told us that agency staff were not used. The service used bank staff, and these were staff familiar with patients as much as possible. Staff were swapped between wards on a shift-by-shift basis if there were shortages or incidents on other wards. Again, staff on the wards with less violence and aggression tended to be sent to cover busier wards.
- Patients and staff told us that one-to-ones and leave were rarely cancelled because there were not enough staff.
- The trust provided a preceptorship programme for newly qualified nurses. This was extensive and staff completed a variety of practice and reflective work before they were signed off. Trust policy allowed nurses on preceptorship to take charge of a ward, and this included when they were the only qualified nurse on duty, and in stand-alone units such as Rockley House.
- All patients had a consultant psychiatrist who was their responsible clinician. Some wards had a junior doctor. Advanced practitioners worked on wards that did not have a junior doctor. An advanced practitioner was a senior nurse (band 8a) who had completed additional training to provide physical healthcare for patients.
- Cover at night was provided to all the wards by an advanced practitioner who led the hospital at night (HAN) team. The HAN team provided a service from 5pm to 9am. One of the advanced practitioners in the team was a non-medical prescriber, and another two were undertaking a non-medical prescribing course. They were on call as the first point of contact for physical healthcare problems and emergencies for all the wards.
- Trust information showed that up to December 2015 the average mandatory training rate for forensic inpatient services was 80%.The information showed that training levels were very low in some areas. For example, 14 wards were below 75% for basic life support training and 10 wards were below 75% for immediate life support training. The trust confirmed that there had been problems with providing basic and immediate life support but this had now been resolved. Other training information figures had improved at the time of our inspection. Ward managers received information from a central training department each month, but were not able to access the data themselves.

Assessing and managing risk to patients and staff

- We looked at 81 care and treatment records across 18 wards.
- All patients had a risk assessment. The assessments did not always reflect changes in risks, and care plans generated from them were often generic and not tailored to the patient. For example we saw the phrase “utilise de-escalation techniques” used, but no description of what specific interventions or actions may work with that particular patient. However, when we discussed this with staff they understood what risks individual patients presented and how to work with the patient to manage them. It was not clear if the knowledge staff had had not been recorded, or if the information had not been transferred across from the old system into the trust’s new electronic care record.
- The psychology team led on risk assessment in the medium secure services. They primarily used the historical clinical risk management-20 (HCR-20), a research-based tool for assessing and managing the risk of violence.
- Blanket restrictions were used only when justified. Staff were familiar with the idea of blanket restrictions, and spoke with us about the balance of working in a secure environment with the use of least restrictive practice. Restrictions were determined at ward level, so varied between the wards. We saw that on some of the wards there was open access to kitchens, laundry rooms, telephones and outdoor space. Patients had personalised their rooms. Staff risk assessed items that each person was allowed to have in their room, such as cables and electrical equipment. Ward managers carried out a restrictive practice audit. This identified potential restrictive practices, asked if restrictions were happening, and if so what the rationale was. For example, there were no set bed times, but stimulus (such as televisions) were turned off at midnight during the week and 1am at the weekend to promote healthy sleep patterns.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- The service rarely had informal patients. Patients were detained under the Mental Health Act, and many were subject to Ministry of Justice restrictions.
- Staff were familiar with observation procedures, and aware of potential environmental and ligature risks in the building and how to manage these. Each ward had a minimum time period that all patients and areas of the ward would be routinely checked. Staff were aware of the trust's search policies and had training in these. Each ward had a security room or quiet area where pat-down searches could be carried out when patients returned from leave. There were hand held metal detectors to support this.
- In the six months to 31 December 2015, in the forensic inpatient services, there had been 222 incidents of the use of restraint of 68 different service users. These figures are low for a service of this type. Of these 12 were on Eskdale ward and 11 on Rydal ward. There were 19 incidents of the use of prone restraints, eight of which occurred on Eskdale Ward. Four of the seven prone restraints on Rydal ward resulted in rapid tranquilisation of the service user.
- Records showed some evidence that patient's vital signs were monitored after rapid tranquilisation had been administered. However, these were not clearly or consistently recorded in accordance with the National Institute for Health and Care Excellence (NICE) guidance (NG10): violence and aggression: short-term management in mental health, health and community settings.
- Staff were provided with a "see, think, act" booklet. This promoted an understanding of risk and advised staff to deal with and report potential issues, even if they seemed minor, to prevent them from escalating. We observed staff de-escalating potentially volatile situations, providing reassurance to distressed patients and encouraging them to move away from a potential argument.
- There were 92 incidents of the use of seclusion. Hayeswater Ward had the highest number of incidents (43) followed by Buttermere (16). A seclusion review was carried out by a CQC Mental Health Act reviewer in August 2015. The recommendations from this review had been addressed. Seclusion records were completed correctly, in accordance with the Mental Health Act code of practice. However, at night the advanced practitioners (senior nursing staff with additional training) routinely carried out four-hourly reviews of patients in seclusion. On Eskdale ward, advanced practitioners completed four-hourly seclusion reviews, usually completed by medical staff, during the day as well as at night.
- Staff had completed safeguarding training. They were aware of what a potential safeguarding concern might be, and knew what to do to report this. The forensic service had a local safeguarding policy, and local safeguarding leads. There was a "red button" on the trust's intranet that staff used to seek advice or raise a safeguarding concern. All the wards had safeguarding information displayed.
- Medication was ordered and stored correctly. A pharmacist visited the wards each week. We reviewed a sample of medication charts on all 18 wards and found medication errors on each ward. Some of these related to consent to treatment forms under the Mental Health Act not having all the necessary medication recorded, or being written out to the wrong ward or hospital. Medication charts were not always completed correctly. This included not specifying the minimum time between doses of medication. There were gaps on medication charts where it was not clear if the medication had not been given, or if the nurse had forgotten to sign for it.
- All nurses completed a three-stage medication management competency assessment before they administered medication alone. Staff were open about reporting medication errors, and we saw examples of where this occurred. It was reported on the incident reporting system, and staff worked through a medication competency workbook which included reflective and practical work for dealing with the error. There was a medication management team that supported staff and assessed their competence.
- The trust had a five-stage self-administration of medication policy for patients. At stage one the patient took medication supervised by staff, and at stage five patients collected the medication from pharmacy and administered it themselves. The process started in the treatment wards, and many patients in the step-down/ pre-discharge wards had progressed to stage five.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- The Edenfield Centre had a designated child visiting room in the reception area. An allocated social worker was responsible for identifying any safeguarding concerns and approving child visits to the hospital. The Lowry Unit had a designated family visiting room on the corridor between Isherwood and Delaney wards.

Track record on safety

- The forensic inpatient wards had two serious incidents reported between 10 March 2014 to 23 January 2016.
- One of these incidents involved a fire on a ward. Staff told us that since the trust-wide smoking ban in January 2015 there had been an increase in contra-band items on the wards, particularly lighters. In response, the trust had introduced smoking cessation workers, and encouraged patients to use nicotine replacements.

Reporting incidents and learning from when things go wrong

- The trust used the electronic datix system for recording and monitoring incidents. Staff knew what to report and how to report it on datix. Once reported, the electronic forms were sent to managers and other relevant staff for review. For example, if there was a fire then the form would also be sent to the fire officer. If further information was required, this was requested and provided through datix, and action plans were requested and updated.
- Ward managers attended an operational leadership group meeting with service managers and senior operational staff. Incidents and learning were discussed at these meetings, and shared across the trust.
- The trust had reviewed and increased its rating of the ligature risk presented by some of the windows following a serious incident. The trust had implemented a staged plan to prioritise and refurbish or replace the effected windows.
- Staff received feedback on the outcome of investigations through monthly staff meetings and supervision. Incidents and current 'hot-spots' were standing agenda items. The trust emailed all staff a monthly lessons learnt newsletter. This shared learning across the trust.
- Staff told us that when serious incidents happened they had been debriefed. Most staff told us they felt supported after incidents, though others felt that the trust had been unsympathetic.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We looked at 81 care and treatment records across 18 wards.
- Patients were usually admitted to the medium secure services from prison or another hospital, or were transferred between wards. Patients were usually admitted to the low secure services from another service. Most patients had already been assessed before they were admitted or transferred to the hospital.
- Patients had a physical healthcare assessment on admission. The forensic service had a specialist physical health care department. The department ran three clinics a week, attended by a local GP, so that patients' physical health needs could be addressed. Assistant Practitioners coordinated the clinics and supported junior medical staff on the wards to meet patients' physical healthcare needs.
- All patients had care plans. Some of the care plans were recovery focused and involved the patient in their development. However, across the service the care records were not consistently personalised, holistic or recovery orientated. Some wards used 'My Shared Pathway', a recognised care-planning tool for patients in forensic services that is recovery and patient focused. 'My Shared Pathway' was separate to the main care plans on the trust's electronic record system.
- The trust had changed its electronic care record system. The new system included a set of up to nine standardised care plans that could be modified for individual patients. The trust acknowledged that there were still problems with implementing the new system, and were working to address this. Staff told us that it could be difficult to find information on the new system, and this was demonstrated further when we asked them to find information for us. Staff were able to describe a patient's care to us, but not always able to find it on the system.

Best practice in treatment and care

- A psychologist was assigned to each of the admission and treatment wards and provided one-to-one treatments for patients that included relapse prevention and psychosocial interventions. The service offered psychological therapies recommended by the National Institute for Health and Care Excellence (NICE). This included cognitive behavioural therapy as recommended in NICE guideline CG178: psychosis and schizophrenia in adults: prevention and management. Other therapies recommended by NICE for the treatment of other mental health problems, such as anxiety, depression and personality disorders were also delivered. This included cognitive analytical therapy and dialectical behavioural therapy. The NICE guideline QS88 for personality disorders: borderline and anti-social recommended group therapy for patients with a diagnosis of anti-social personality disorder. Psychologists facilitated this group in the form of a ward psychosocial intervention programme.
- The service delivered art-based therapies. This was in accordance with NICE guideline CG178: psychosis and schizophrenia in adults: prevention and management that recommended art therapies to assist in promoting recovery, particularly in people with negative symptoms.
- Patients had access to physical healthcare, which included specialist services when required. Staff used the 'modified early warning system' chart to record patient's vital signs and easily identify if there were changes to their observations that needed to be reviewed.
- Staff used recognised rating scales to measure assess and record outcomes for patients. This included the health of the nation outcome scale for secure services (HoNOS-secure). All wards used the mental health safety thermometer tool to assess patients' general well-being on the ward. The ward manager carried out a monthly spot check on a particular day's levels of self-harm, violence and aggression, medication error, restraints, and psychological safety. This information was reviewed by a central team who provided feedback to the manager about any themes that needed to be addressed.

Skilled staff to deliver care

- The trust employed a range of mental health professionals, which included psychiatrists, mental health nurses, psychologists, occupational therapists, social workers and healthcare assistants.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Staff completed an induction programme. This included trust-wide elements, and specific local information about working in forensic services. The programme was tailored to staff roles. For example all staff were required to complete a security and key induction, but only qualified nurses completed a medication management competency assessment.
- Staff told us that they received supervision every four to six weeks. Information provided by the trust for the year to January 2016 showed that the average rate for clinical supervision across all the wards was 72%.
- The percentage of non-medical staff across the whole trust that had an appraisal in the 12 months to 25 January 2016 was 82%. Non-medical staff in forensic services inpatient/services during the same period averaged at 88%.
- Staff told us that they were able to access non-mandatory training through the trust. Staff had completed psychosocial interventions training, and mentorship. Other staff had completed qualifications and credit frameworks (QCFs, formerly called national vocational qualifications (NVQs)), degrees and master's degrees.

Multi-disciplinary and inter-agency team work

- Patients were discussed regularly in clinical team meetings (CTMs). The consultant led the CTMs, which included nursing staff, psychology, pharmacy and a social worker when required. The format varied between wards, but patients were usually discussed or seen at least once a fortnight.
- Occupational therapists did not routinely attend the CTMs. Staff told us this was because in June 2015 occupational therapists were given a key performance indicator to deliver 25 hours of activity to each patient. The trust told us that this target had already been met, and the decision for occupational therapists not to attend the meetings was made to increase the quality and range of activities offered. Staff from various disciplines agreed it was of benefit to patients to have more direct contact with occupational therapists on the ward. However, staff expressed concern that patients' care planning did not involve direct input from an occupational therapist when discussing a patient's recovery and daily living skills.
- Patients admitted to the medium secure wards were part of a "stream". Typically, a patient would be admitted to an admission ward for a period of assessment, then transferred to an ongoing treatment ward, then moved to a pre-discharge or step-down ward to work towards discharged from the service. Patients usually remained with the same consultant, and their associated team, throughout their pathway through the service.
- There were handovers between nursing staff at the beginning and end of each shift.
- The service had good working relationships with teams outside of the organisation. For example, the risk and patient safety (RAPS) team had effective relationships with a local police liaison officer. When police support was required, they were more likely to be dealt with by police offers that were knowledgeable and sensitive to the mental health needs of service users.

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

- Training in the Mental Health Act (MHA) was not part of the trust's mandatory training programme. Information provided by the trust showed that up to 21 January 2016, on average 24% of staff across forensic services had received training in the MHA.
- Staff told us that they had received training. It was not clear what this had included. The trust had implemented an eLearning package on the MHA. Some staff told us they had received training on the MHA during induction, and others said they had completed an eLearning package.
- On eight of the wards, there were consent to treatment forms that did not accurately reflect the medication the patient was prescribed, or were out of date. This meant that nursing staff had administered medication to patients without a valid MHA consent form. These issues were raised with the managers of each of the wards.
- Patients had their rights under the MHA explained to them when they were admitted to the service. The MHA code of practice recommends that even where patients have understood their rights they should have them explained to them again at a maximum of three monthly intervals. The care records did not show that this had happened. Staff told us that patients would only have

Are services effective?

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their rights explained to them on admission, if they were transferred to another ward, or if there was some other change. Staff said that otherwise, they would be explained every six or twelve months. However, the care records did not show that this had happened.

- Staff knew how to access the trust's MHA team for advice, and the trust's MHA policies on the intranet. The trust's electronic care records system had a section for legal paperwork. The MHA team monitored the implementation of the MHA and carried out regular audits.
- Independent mental health advocates (IMHAs) visited the wards each week. The wards displayed information about the IMHAs so that patients could contact them. Patients were aware of the IMHA service.

Good practice in applying the Mental Capacity Act

- Training in the Mental Capacity Act (MCA) was not part of the trust's mandatory training programme. Information provided by the trust showed that up to 21 January 2016, on average 14% of staff across forensic services had received training in the MCA.
- There were no Deprivation of Liberty Safeguards (DoLS) applications made in the last six months.
- Staff understanding of the MCA and DoLS was variable. Staff knew how to find information about this on the trust's intranet. Care records included evidence of informed consent, but not always an assessment of capacity. It was not clear if this was due to the information not being recorded in the trust's new electronic record system. We saw that patients had their capacity assessed with regards to whether they could make decisions. For example, about their finances or physical health. Where patients had been deemed to lack the capacity to make a decision then they had been treated in their best interest.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- Most of the interactions we observed between staff and patients were friendly and respectful. Staff were responsive to patients' needs. Most of the patients we spoke with were positive about the service they received. Patients told us that they were treated with respect by staff, and most patients found most staff supportive. Staff spoke about patients in a positive and recovery focused manner.
- Staff told us that male staff working on female wards were aware of issues of privacy and dignity. Some female patients reported that not all staff knocked before entering their rooms, and this made them feel uncomfortable, particular if it was a male member of staff. Patients on some of the wards had been provided with signs to stick on their shower curtains so that staff were aware they were likely to be undressed.

The involvement of people in the care that they receive

- Patients were shown around the ward on or shortly after admission. Welcome packs were available on some of the wards.
- Most of the patients we spoke with felt involved in their care planning, even though they may not agree with the treatment plan. Patients were offered a copy of their care plan.
- The service provided an advocacy service, which was advertised on each of the wards. Advocates visited most wards each week or when requested by patients.
- The specialist services network provided a family, friends and parents information pack for carers. This included information about the role of advocacy, how to make a complaint or compliment, discharge planning, carer support groups, how they could get involved in the service, and an explanation of observation levels, care programme approach (CPA) meetings and the Mental Health Act. The carers we spoke with were positive about the service. There were facilities for families to visit their relatives in the hospital.
- Patients and carers answered the "friends and family test" by using electronic terminals placed around the trust. During October to December 2015. 216 patient responses were recorded in adult forensic services. Most answers scored above 85% (areas of strength) or from 75%-85% (areas for improvement). Most patients responded that staff treated them with respect and they were listened to. 31% of low secure respondents and 43% of medium secure respondents thought the activities available were fair or poor.
- The wards had regular, usually weekly, community meetings. Patients and staff discussed issues on the ward. This included concerns or problems, and suggestions for patient activities.
- Patients were involved in decisions about the service. For example, patients were involved in the recruitment process, and supported staff to run sessions in the trust's recovery academy.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- The average bed occupancy over the 6 months prior to inspection for the forensic inpatient wards was 97%. Of the 18 wards, 17 had bed occupancy over 85%.
- Patients had identified accommodation before they were discharged from hospital, and this may have included periods of trial leave. Patients had a bed when they returned from leave.
- Patients were primarily moved between wards as part of their care pathway through the service towards discharge. However, patients could be moved if there were conflicts between themselves and another patient.
- In the 6 months prior to inspection, there had been no delayed discharges. Two patients were readmitted within 90 days of discharge.
- The average length of stay for patients discharged in the twelve months prior to inspection was 579 days, and for patients at the time of inspection was 821 days. The average length of stay for patients in low secure services was 12 to 18 months. There were weekly bed management meetings across medium and low secure services that discussed potential admissions to and discharges from the service. Service Managers met every six weeks with NHS England to discuss access and discharge of patients.

The facilities promote recovery, comfort, dignity and confidentiality

- All the wards had clinic rooms, activity rooms and private space for patients. Some of these facilities were shared between wards. The activity rooms were different on each ward, but typically had games, art and craft materials, and games consoles. The three women's wards in the medium secure unit shared a hairdressing room. Patients had access to outdoor space. The outdoor space for Silverdale and Coniston wards could not be accessed directly from the ward, so patients had to be escorted to it by staff.
- There were payphones on all the wards. Patients on some on some of the wards had their own mobiles phones.
- Most of the wards had access to a kitchen that patients could use to cook meals with support from staff. Patients had access to hot drinks and snacks. Open access to the kitchens was determined by a risk assessment of patients. For example, the kitchens on the medium secure assessment wards tended to be locked, but on the step-down/pre-discharge wards they were open.
- All patients had their own bedroom. Patients had lockable bedroom doors and open access to their rooms. Patients had a safe lockable area for their possessions.
- The trust had a target to provide all patients in forensic services with 25 hours of activities per week. This was led by occupational therapy staff and the recovery workers on the wards. Patients visited the Patterdale Centre which included a gym, bikes, pottery, computers and guitars. The service had its own offshoot of the recovery academy for patients who could not leave the unit and attend the main recovery academy in the hospital, and was very patient-focussed. Patients attended therapy and activity groups which included a pre-discharge course, living with a personality disorder, peer mentoring, and changing offending behaviour.
- A national charity provided real-work experience for patients and supported them to gain qualification and credit frameworks (QCFs, formerly called national vocational qualifications (NVQs)). This included painting and decorating, and car valeting. Patients on the pre-discharge wards had individual activity plans in the community they were moving to, rather than in-house activities.

Meeting the needs of all people who use the service

- The wards displayed information for patients, and there were information leaflets available. This included information about local services, patients' rights, treatments, and the day's activities.
- Ward managers requested interpreters when required. Food was available that met religious and dietary requirements.
- The service had a chaplaincy service, who visited the ward at least once a week. A local imam visited the

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

service weekly, for patients who practiced Islam. Each ward had access to a multi-faith room. Two patients who were religious told us that they had appropriate access to facilities and spiritual support.

Listening to and learning from concerns and complaints

- The wards displayed information about how to make a complaint.
- Information provided by the trust showed that in the 12 months prior to inspection there had been 54 complaints from 13 wards. Of these, five had been fully upheld and seven partially upheld. During the same time period, there were 26 compliments.
- The wards displayed information about how to make a complaint. Most patients told us they knew how to make a complaint, or that they would talk the manager or their advocate. Staff were familiar with the complaints process. They told us that most complaints were dealt with and resolved at ward level. Complaints were a standing agenda item at the operational leadership group meeting for ward managers and senior staff. Staff received feedback about investigations and complaints through staff meetings, handover and within clinical supervision.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Staff were aware of and agreed with the trust's vision and values. Posters advertising these values were located on all the wards, and they were incorporated into staff members' clinical supervision to rate their performance against. Staff name tags were on lanyards that had the trust's vision and values printed on them.
- Staff were aware of the trust's policies and know how to access them on the trust's intranet.
- Most staff were aware of who the senior managers within the forensic inpatient service were, and told us they visited the wards regularly.

Good governance

- The use of key performance indicators (KPIs) to gauge performance of individual ward teams was not consistent. We saw an example of a KPI being used to measure and manage high rates of sickness on one ward (Eskdale). The only KPI that was successfully used across every ward was a target to provider service users with at least 25 hours of recreational activities per week. Service users told us that they were aware and pleased by this increase, as they felt less bored and more motivated in their recovery.
- The trust had corporate systems for monitoring and supporting local services. This included electronic logging of staffing levels, staff supervision and appraisal, incidents and complaints.
- The trust had KPIs to manage the performance of staff and teams within the forensic inpatient service. The information was provided each month, and ward managers used this to manage their teams. The information included recruitment, sickness, ward activity, observation, overdue or missing recovery plans, mandatory training and incidents.
- Ward managers had authority to make decisions about their services, and raise their concerns and ideas with senior managers. The trust ran a "dragon's den" scheme where any staff could bid for money to fund one-off projects. The trust also provided a minor schemes fund for environmental improvements. For example, the money had been used to replace flooring and worktops on Dovedale ward, create a Zen garden on Loweswater ward, and install a new kitchen for patients and their families to use on Borrowdale ward.

Leadership, morale and staff engagement

- Most nursing staff and health care assistants were positive about working in the service, and felt supported by their managers. Staff felt that they worked well as a team, and were supported by one another. Staff felt able to raise concerns. Occupational therapy staff were positive about their role but felt they had not been involved in the decision to take them out of the multidisciplinary team meetings. They were concerned that this had reduced their professional identity within the service.
- Ward managers had attended or were taking part in leadership courses.

Commitment to quality improvement and innovation

- Medium and low secure services were part of the Royal College of Psychiatrists quality network for forensic mental health services. Staff from forensic services across the country assess and benchmark one another against a set of quality standards. Medium and low secure services were last assessed in October 2015. The low secure assessment had identified 13 actions that needed to be addressed. These were mostly related to the building and how this impacted on patient care, and these had been resolved when the service moved to a new building.

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 Care and treatment must be provided in a way that is safe for patients. **How this regulation was not being met** Rapid tranquilisation was not carried out in accordance with NICE guidance, as patients did not always have physical healthcare checks carried out afterwards, which may put them at risk. This was a breach of **regulation 12(a)(b)** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. **How this regulation was not being met** On 14 wards less than 75% of staff had completed basic life support training and on 10 wards less than 75% had completed immediate life support training. This may put patients at risk should they require life support in an emergency. This was a breach of **regulation 18(2)(a)** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014