St Magnus Hospital

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

Ratings

Overall rating for this location	**Outstanding** ☆
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Good** ●
Are services well-led?	**Outstanding** ☆

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.

Summary of findings

Overall summary

We rated the core services at St Magnus Hospital as **Outstanding** because:

- The ward environments were safe; all areas were exceptionally clean and very well furnished.
- The hospital had a stable leadership team. Senior managers and clinicians were approachable and inspired their staff teams.
- The hospital was very well resourced with nursing and other clinical staff to meet safely the needs of the patients. Staff completed all risk assessments and care plans with patients and carers, and regularly reviewed and updated them.
- Many patients had complex physical health problems. Patients had very good access to physical healthcare. Some of the nurses were qualified general nurses, others received training in physical health conditions, and a GP visited the hospital site twice a week.
- Staff were knowledgeable of the Mental Health Act and Mental Capacity Act and applied the Code of Practice principles well for both. Advocates assisted patients at multidisciplinary care reviews.
- Staff were fully committed to working in partnership with patients and carers. Carers were involved in all aspects of care and treatment and were supported by hospital staff. Carers were invited to attend hospital training sessions for example, dementia awareness training.
- Staff were extremely caring of patients and visiting clinicians remarked on how well treated the patients were.
- There was a full range of facilities for patients including a therapy suite, a gymnasium, and a sensory room. All meals were prepared on–site by the chef and his team using local produce.
- Staff had access to an on-site education department that was accredited to provide a range of health and social care certified qualifications.
- Sickness rates were below 1%. There were no qualified staff vacancies. Staff felt empowered and motivated to do their jobs well and felt supported by their managers.
- Senior managers had developed initiatives to retain and develop their own workforce. This included sponsoring staff to complete nurse registration for both mental health and general nursing, and had recently sponsored five senior support workers to become associate nurses. Psychiatrists were supported to pursue relevant special interests for example, gaining experience in neuropsychiatry.
- Subsidised short-term accommodation and subsidised transport was provided for staff.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards	Outstanding ☆	The environment and skilled staff kept patients safe. Risk assessments were up to date and regularly reviewed. Care plans were holistic and incorporated the views of patients. Patients, carers and visiting professionals reported that staff were very caring. Physical health needs were well met. Senior managers and clinicians inspired their staff teams.
Wards for older people with mental health problems	Outstanding ☆	The environment and skilled staff kept patients safe. Risk assessments were up to date and regularly reviewed. Care plans were holistic and incorporated the views of patients. Patients, carers and visiting professionals reported that staff were very caring. Physical health needs were well met. Senior managers and clinicians inspired their staff teams.

Summary of findings

Contents

Outstanding ☆

St Magnus Hospital

Services we looked at

Forensic inpatient/secure wards; Wards for older people with mental health problems;

Summary of this inspection

Background to St Magnus Hospital

St Magnus Hospital is an independent mental health hospital run by Oldercare (Haslemere) Limited. The hospital provides a highly specialist, national service to predominantly older age men with behavioural and psychological symptoms of dementia, cognitive impairment and/or enduring mental illness. The average age of patients was 68 years. There are two core services at the hospital, a low secure/forensic service, and locked wards for older people with mental health problems and high dependency needs.

The hospital shares a site with Rosemary Park, a 66-bed nursing home, and is registered as a single location. At the same time as we inspected the hospital, an adult social care inspection team inspected Rosemary Park Nursing Home; their findings will be reported in a separate report.

There are 86 beds across seven wards in St Magnus Hospital; 83 beds were in use during our inspection. Seventy-eight patients were detained under the Mental Health Act (MHA) and five patients were subject to Deprivation of Liberty Safeguards (DoLS) as part of the Mental Capacity Act (MCA).

There are seven wards at St Magnus Hospital, three low secure/forensic wards and four locked wards for older people with mental health problems.

We inspected all seven wards:

Sycamore Ward nine beds for men, low secure, admission and assessment

Willow Ward nine beds for men, low secure, continuing care

Oak Ward 15 beds for men, low secure, continuing care

Cowdray Ward eight beds for men, locked admission/high dependency ward

Petworth Ward 15 beds for men, locked, continuing care

Park House 18 beds for men, locked, continuing care, progressive dementia

Goodwood Ward 12 beds for men, locked, continuing care, enduring mental

illness

St Magnus Hospital and Rosemary Park Nursing Home are registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Accommodation for persons who require nursing or personal care.

There is a registered manager in place.

We have inspected the services provided at St Magnus Hospital four times since 2011. At the time of the last inspection in August 2015, St Magnus Hospital was rated as good, there were no requirement notices.

Our inspection team

The inspection team was led by Russell Hackett.

The team that inspected the services comprised of three inspectors, an assistant inspector,

a pharmacy specialist, three qualified mental health nurses and two experts by experience (a person that has experience of mental health services as a patient or carer).

Why we carried out this inspection

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

Summary of this inspection

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?

Prior to the inspection visit, we reviewed information that we held about the location, including a summary of outcomes from Mental Health Act reviewers' inspection visits completed in the past year.

During the inspection visit, the inspection team:

- visited all seven wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 19 patients who were using the service;
- spoke with the registered manager and managers or acting managers for each of the wards;
- spoke with 38 other staff members, including doctors, nurses, occupational therapist, and social worker;
- spoke with the local, visiting GP;
- spoke with the visiting speech and language therapist;
- held a staff focus group for all staff members up to the level of ward manager or equivalent - 25 staff attended;
- spoke with and received feedback about the service from 11 carers of patients;
- spoke with an independent mental health advocate (IMHA);
- attended and observed four hand-over meetings and five multidisciplinary meetings;
- collected feedback from 17 patients using comment cards;
- looked at 37 care and treatment records of patients;
- carried out a specific check of the medication management on all wards;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with twenty nine patients and received seventeen comment cards. Patients that were able to communicate with us told us they knew their named nurse, key worker, care staff and the hospital managers. All said they had been involved in planning their care and were supported by staff to understand their care plans and were offered copies of their care plans. Patients described having their rights under the Mental Health Act explained to them regularly.

The patients we spoke to all knew there was an advocate available to the wards and felt able to see them if they wished to. Patients could complain to the advocate or one of the management team. Patients who had complained spoke of positive responses; they told us they usually received feedback. Patients said all staff showed them respect and were polite.

Patients liked having their own rooms and spoke about feeling their property was safe in their rooms as they could have their own key fobs. All patients felt the wards were very clean and well maintained and spoke highly of the cleaning staff.

Patients who had been restrained said this had been done with care and only after other efforts to calm them down had not worked. We heard about special individual care plans of how best to keep patients safe when distressed.

Patients told us they had a choice of activities they liked to do. Patients enjoyed going out of hospital into the community. Patients told us they were able to speak to relatives on the telephone. Staff supported relatives to visit and the systems around visits to patients appeared to work well.

Patients and their carers were encouraged to share information about their likes and dislikes, interests and

Summary of this inspection

hobbies. This information was displayed in the bedrooms. A patient satisfaction survey was undertaken earlier in the year and most patients surveyed reported that staff treated them with dignity and respect.

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?

Good

We rated Safe as **Good** because:

- The design of the wards, and the additional measures taken, allowed staff to observe freely all communal areas of the wards.
- Ligature risk audits were thorough and up to date. Staff had appropriate measures in place to manage safely ligature risks that remained.
- The wards were extremely well equipped; the furniture and furnishings were to a high standard. All areas were exceptionally clean and well maintained.
- Ward managers and senior nurses completed daily environmental risk assessments of neighbouring wards.
- The staffing allocation for each ward had been worked out using a tool based on patients' needs. All wards had sufficient staff to carry out their duties. There were no trained nurse vacancies at the hospital. Additional bank staff hours were used for additional caring duties.
- Agency staff were rarely used.
- Senior managers had supported staff to undertake additional training. Five associate nurses had graduated since the scheme started. Qualified general nurses were employed and sponsored to complete their mental health training.
- Sickness levels were below one per cent.
- Mandatory training was above 75% in all areas bar three, and above 90% in most areas. The on-site education department managed and provided mandatory training and other accredited health care courses.
- Seclusion had been rarely used and there were no dedicated seclusion facilities in either service. When seclusion was used, patients were escorted to their bedrooms and supervised in accordance with the hospital policy.
- Care records demonstrated good practice. Risks were assessed, rated and updated using recognised tools and processes.
- There were good policies in place for observation. All wards had observation charts detailing the frequency with which individual patients were observed. We saw observations being conducted and staff were able to tell us of the importance of good observation. Frequencies of observation were reduced at night as appropriate.
- There was good medicines management across all wards.
- There had been one serious incident in the past 12 months. Safety improvements were in place following the incident.

Summary of this inspection

- Incident reporting was paper-based. Staff were encouraged by senior managers to report high and low-level incidents.

However:

- Staff reported that they did not always receive feedback from incidents they had raised.

Are services effective?

Good

We rated effective as **Good** because:

- Care records were modularised and mostly comprehensive. Care plans had been implemented on admission and included information from the previous placement and from carers.
- Care plans were holistic, recovery-oriented to the aims of the service which sought to move patients along an internal care pathway to less restrictive environments, and were personalised in all cases.
- Care records were stored electronically and were accessible by nursing staff. Paper-based copies of care records were available in ward offices for support workers to view.
- There was good access to physical health care. Some of the qualified nurses were general nurses. In addition, a GP visited the site twice a week from the local surgery.
- Physical health care needs were well documented and planned care was evident. Specialist swallowing assessments and care plans had been completed for some patients by the visiting speech and language therapist. These were to a very high standard and enabled the on-site chef to produce food re-textured to a prescribed consistency.
- National Early Warning Scores (NEWS) were completed at least weekly for all patients. This enabled early detection of potential physical illness or disease.
- Clinical staff took part in clinical audit. For example, audit of the use of covert medication. This ensured that best practice in specific treatment areas was attained.
- Staff were experienced and qualified for their role. Many staff had been at the hospital for many years.
- Induction training was overseen by the on-site education department. All support workers had attained, or were working to attain, the Care Certificate.
- Staff received managerial and clinical supervision. Supervision records were up to date.
- Staff received annual appraisals and copies of appraisals were stored in personnel files.
- Handovers and other multidisciplinary team meetings were effective. Appropriate information was shared and staff were encouraged to contribute and were respectful of each other.

Summary of this inspection

- Staff had received training in the Mental Health Act 1983 (MHA) at induction. MHA records were completed, up to date and stored appropriately. Staff explained patients' rights under the MHA to them monthly. Consent to treatment was well documented and patients had capacity assessments documented.
- Staff had received training in the Mental Capacity Act 2005 (MCA). Capacity to consent was assessed and recorded on a decision-specific basis. Applications for deprivations of liberty safeguards (DoLS) assessments were completed as required. Five patients were subject to DoLS authorisations at the time of inspection.

However:

- Some of the care records did not include evidence of physical examination being completed on admission and nurse assessment components were incomplete on four care records.
- Although MHA training was covered at staff induction, it was not an annual mandatory training requirement.

Are services caring?

Outstanding ☆

We rated Caring as **Outstanding** because:

- We observed staff interacting with patients, many of whom were vulnerable or displayed difficult to manage behaviours. Staff were extremely patient, polite, respectful of privacy and dignity, and knowledgeable of each person and their needs.
- Patients in the older adult wards had laminated posters in their rooms that gave a brief biography of themselves, their likes and interests, and included advice for staff on how best to respond to each individual if demonstrating agitated behaviours.
- Staff demonstrated kindness and sensitivity in the way they interacted with patients.
- Patients reported that staff were very caring and respectful. All carers fed back how well looked after their relatives were. Some carers stated this was the best possible service for their relative.
- A carers support forum was in operation to offer advice and assistance to carers, this was well used. In addition, carers were invited to attend training sessions at the in-house education department, for example, dementia awareness training.
- Carers also reported feeling cared about by staff who always asked how they were and whether they required any further assistance or information.
- All patients were encouraged to participate in their own care-planning, risk assessments and multidisciplinary meetings. Ward staff offered assistance in these areas and

demonstrated patience and understanding when people did not wish to be involved. The independent mental health advocate (IMHA) routinely offered assistance to patients attending reviews of their care.
- Staff actively encouraged family members and carers to be involved in their relatives' care.
- Staff demonstrated caring attitudes towards each other; this was noticeable in the interactions we observed. Staff were very supportive of each other, and offered assistance to each other without needing to be asked.
- Results from patient surveys demonstrated that patients were positive about the service they received and the staff that provided their care to them.
- Patients were encouraged to maintain their independence through choices they could make throughout the day with regard to meals, activities and leave. Staff assisted the patients to make these choices.
- Ward staff were knowledgeable about patient interests and assisted some patients to pursue their hobbies by arranging external visits.
- Staff from St Magnus accompanied patients throughout their stays in general hospitals.
- Visiting professionals praised the care that patients received. One professional clinician remarked that the care given was 'extraordinary'.

Are services responsive?

Good

We rated Responsive as **Good** because:

- Patients were moved along the internal hospital care pathway appropriately, based upon clinical progress.
- The number of delayed discharges was low and due to factors outside of the control of hospital staff, for example, funding responsibilities.
- All wards were very well equipped. Additional equipment was available as required to support care and treatment.
- The quiet rooms used for patient visiting were adjacent to the ward and were exceptionally well furnished.
- External secure garden space was provided. The grounds were large and adjoined a National Trust woodland area.
- Patients were able to personalise their rooms and those who were able to manage the security of their personal effects had key fobs. This was regularly reviewed.
- There was access to activities during the week led by activity staff which included bringing in external activity co-ordinators.

Summary of this inspection

At weekends ward staff led more relaxed activities. The majority of the activities were run in groups. We saw patients actively engaging with ward staff or external activity co-ordinators, for example, dancing and singing during karaoke.

- Accessible information was available on patients' rights, making a complaint and ward-based activities. Staff and advocates regularly assisted patients to have their voices heard.
- The standard of food was very good. It was prepared on-site by the chef and his team using local fresh produce. Patients had a choice of meals and the food was re-textured for those patients who had assessed difficulties in swallowing.
- There was access to appropriate spiritual support. A priest visited all wards weekly and was able to make arrangements for the spiritual needs of patients of other faiths to be met.
- There had been a low level of complaints made. We observed that complaints were handled according to the hospital policy and patients received feedback and an apology where appropriate.

However:

- Therapeutic activities were not individually tailored to meet patients' needs. Staff and patients were not clear what individualised activity work was happening across the wards.

Are services well-led?

Outstanding ☆

We rated well-led as **Outstanding** because:

- Patient care was at the centre of the hospital's values and was central to the statement of purpose. All staff reported that high quality patient care was their main aim.
- Senior managers and senior clinicians were daily visitors to the wards. They knew all of the patients and all of the staff well.
- The senior management team were very experienced and capable and had worked together over many years. Senior managers and clinicians were approachable and inspired their staff teams.
- The system established for the provision and monitoring of training was extremely efficient and effective. It was personalised to each staff member and provided by the tutors from the on-site education department.
- Staff received both individual and group supervision and said it met their needs. Ward managers had systems in place to audit the uptake of supervision.
- All support worker and senior support worker time was spent on direct care activities. Leadership was demonstrated on the wards by the ward manager and the nurse in charge.

Summary of this inspection

- Staff were well qualified and generally very experienced. There were sufficient nurses and support workers to meet all of the patients' care needs.
- Staff retention rates were high and there were no trained nurse vacancies. Initiatives and investments into staffing taken by the senior management team were exceptionally significant for a small stand-alone hospital.
- External clinicians of a very high standard were working through service level agreements with the hospital multidisciplinary team members to provide additional specialist advice, assessments, care planning and treatments
- Systems, processes and policies were in place for the governance of incident management, complaint handling, human resource management, safeguarding, MHA and MCA monitoring
- A risk register had been introduced in the past year and covered corporate risk.
- Sickness and absence rates were low, below one per cent.
- Morale was very high. Staff appeared motivated and satisfied with the level of empowerment they had. They all spoke very positively of the work environment and the support they received from senior managers.
- There were opportunities for leadership training and special interest training.
- Staff were very supportive of each other and ward, senior management and multidisciplinary teams worked effectively.
- Staff were encouraged to feedback on current service provision and were involved in service developments.
- The low secure service took part in the Royal College of Psychiatry Quality Network for forensic services and was assessed as being in the top 30% of forensic services nationally.
- The hospital had a business continuity plan for a range of significant failures or events. The nurse in charge of each ward had devolved responsibility to act on behalf of the hospital management team to call in contractors as required.

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.

- The staff we spoke with demonstrated a good knowledge and understanding of the Mental Health Act (MHA). They told us they had accessed training through the hospital during their induction. However, when we reviewed training records we could see that this training was not mandatory and we were not able readily to see the amount of staff that had completed this training at the time of inspection. We fed this finding back to the hospital who advised that 93% of staff had received training in the MHA during induction or consolidation training and this information was held in staff personnel files.
- All but five patients were detained under the Mental Health Act (MHA) at the time of our inspection. Detentions were either under part two or part three of the Act. All staff were aware of the requirements for authorising leave, and their role and responsibilities as escorts during leave for their patient groups.
- We inspected the detention papers of a sample of patients detained under both part two and part three of the MHA. All detention papers were in good order and stored appropriately with electronic copies attached to care notes and paper copies in the case file. The original documents were retained by the MHA administrator.
- We reviewed all medicine charts. Consent to treatment forms were attached to all medicine charts and copied into the paper care-notes folder. We examined the charts of all patients that required either a T2 or a T3 form for treatment authorisation and all were in good order.
- Staff explained to detained patients their rights under the MHA. This was attempted or achieved and recorded on a monthly basis. This was also subject to audit by ward managers and the MHA administrator.
- The MHA administrator reviewed all detention papers on admission. Capacity and consent to treatment audits were conducted every six months and section 17 authorisation for leave forms were audited monthly.
- Patients had access to generic advocacy and independent mental health advocates (IMHA). Records showed that patients were informed of their rights of appeal against their detention under the MHA.
- Patients had access to mental health review tribunals and hospital managers' meetings and these were logged and recorded in care notes.
- Staff were aware of the MHA Code of Practice and their responsibilities. The hospital employed a MHA administrator whom staff could access for advice and support when needed.
- There was information available on the notice boards on the wards regarding the relevant sections of the MHA that applied to the particular patient group in relation to their detention and treatment, and how to complain to or contact the CQC.
- Willow Ward had folders available in each of the patients' bedrooms with their individual care plans and information leaflets relating to the patient's detention under the MHA. There was also information related to what should happen if a patient were to be discharged from the MHA, whilst they stayed at the hospital, in relation to their rights to leave the ward. This was not posted on the door to the wards but was available on a notice board nearby.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff demonstrated a good awareness of the Mental Capacity Act (MCA) and the guiding principles. They were aware of how the MCA impacted on the patient group and described how the MCA could help when supporting a patient in any decision-making process, such as how to support a patient to manage their finances. We saw mental capacity assessments regularly discussed in the minutes of the multidisciplinary meetings in relation to physical health treatments that were available to the patients.

Detailed findings from this inspection

- The staff told us they received regular updates and training in the MCA. Staff knew how to access the MCA policy and additional information about the Act on the hospital's intranet. The training records indicated that 82% of St Magnus Hospital had completed MCA annual mandatory training.
- Five patients were subject to deprivation of liberty safeguards (DoLS) authorisations at the time of our inspection. These were the only five applications made in a six-month period prior to our inspection. All of the applications were for patients on Goodwood Ward.
- Staff were familiar with the MCA owing to the nature of the patient group, many of whom had impaired capacity. Capacity to consent was assessed, recorded appropriately and decision specific. Assistance was given to patients by the independent mental capacity advocate (IMCA), ward staff, social workers and medical staff to ensure they were given support to make specific decisions.
- We saw examples of best interest decisions taken on patients' behalf for the use of covert medication and management of finances.
- Advice and support on the MCA and DoLS was available from the on-site MHA administrator. The administrator was in turn supported through an agreement with the local NHS mental health trust for specialist MHA advice.
- The covert medication audit up to June 2017 found that all patients who were in receipt of covert medication had a capacity assessment and a best interest meeting for decisions to medicate covertly. We observed that capacity assessments were reviewed every three months. The reviews were recorded in the monthly multidisciplinary team meeting minutes for each patient.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Wards for older people with mental health problems	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Overall	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding

Outstanding ☆

Forensic inpatient/secure wards

Safe	Good
Effective	Good
Caring	Outstanding ☆
Responsive	Good
Well-led	Outstanding ☆

Are forensic inpatient/secure wards safe?

Good

Safe and clean environment

- The wards had clear lines of sight for observing patients. There were convex mirrors used in all areas where full easy sight was not possible. Closed circuit television cameras (CCTV) were in use in communal areas of the wards, and recorded footage from these was reviewed when necessary as part of the incident review process. There were two blind spots on Willow Ward and Sycamore Ward which were not picked up on the CCTV. However, staff told us they regularly checked the corridors and discretely followed a patient if they moved out of view. There were systems in place for staff to provide patient observations and this was well documented.
- There were multiple ligature points on the wards. However, staff had identified ligature points using their hospital's screening tool and completed environmental ligature assessments annually. Patients admitted to the forensic wards were longer term patients that were not a group at risk of suicide and self-harm. In addition, daily walk-around checks and a weekly environmental check on each ward ensured a regular systematic approach to maintain a safe environment. We reviewed a sample of these and saw that most identified risks were either rectified or managed against individual patient risk assessments.
- We noted that the internal en-suite doors had not been identified on the ligature audits for the wards and brought this to the attention of the ward managers during the inspection. Staff were aware of the ligature audits and told us they felt able to manage the individual patient risks. We saw evidence of management of ligature cutters in readily accessible locations. They were stored safely and staff were able to tell us where they could access them if needed.
- The service was commissioned to provide care and treatment for men only, so was fully compliant with the Department of Health guidance on same sex accommodation.
- Resuscitation and emergency equipment was available on the wards and we saw this was regularly checked by staff. Emergency medication was centrally available and all staff were aware of its location. Maintenance schedules for the resuscitation equipment were in date. The wards did not have clinic rooms and the medication was managed from the large nursing offices. The areas in the office for the management of medication were clean and well stocked. Stock items were in date and facilities were available for safe disposal of sharps and waste.
- The wards did not have seclusion rooms and all staff told us that this was not necessary because of their safe interpersonal management of the patients.
- The ward areas were visibly clean and well maintained. We looked at the ward cleaning schedules and saw that regular audits for cleanliness were undertaken by the housekeeping department. This meant that the ward environment was clean and infection control was well managed.
- The equipment used by and for the patients was well maintained, had been assessed and reviewed, and was within date. The wards served food that was freshly made every day from the kitchens on site using local produce. The food was checked and recorded at every meal to ensure it was served at a safe temperature.

Food items were appropriately stored in a lockable area in the staff kitchens. The food on the ward was all in date and correctly labelled. Fridges in the kitchen were regularly checked to make sure food was kept at a safe temperature and this was also recorded.

- The low secure wards had a 24-hour managed reception airlock area where door fobs and personal alarms were allocated to staff and visitors. All staff and visitors had to go through this area in order to access the low secure hospital.
- There was a robust system in place in the reception area using photo identification to ensure that staff and visitor identity was checked and correct door access fobs given when people came in and out of the secure area airlock.
- Alarms were tested on a daily basis by the reception staff as part of their duties. However, there was no document recording this had been completed. This meant there was a possibility that an alarm could be given to a staff member or visitor without there being a record of whether it had been checked to be working.

Safe staffing

- The information provided to us by St Magnus indicated that across the three low secure wards there was only one vacancy for a qualified staff on Willow Ward which was in the process of being filled. We reviewed the staff rotas on all wards and saw this to be the case. The established unqualified staffing levels for all of the wards were met with no vacancies.
- The hospital used a system calculated on nursing hours per patient per day and the hospital general manager reported to the clinical services meeting and senior management team about ward staffing levels across the hospital.
- The wards used a bank of staff to cover any urgent staff absence and shifts were regularly covered by staff known to the ward and employed by the hospital. Agency staff were rarely used. When agency staff were used we were told they were orientated to the ward, but there was no system for recording what was being handed over, which meant security and patient risk related items may be missed.
- In addition to the core numbers on the wards, the ward managers were supernumerary and were able to work as part of the team when necessary to ensure there were suitable numbers of trained staff. The wards were also able to request support from the occupational therapy team to support patients' activities to ensure that the wards' staffing levels were maintained.
- There were sufficient staff on each day shift to carry out physical interventions if required. The number of staff present in the hospital decreased overnight and the hospital was a stand-alone service with no immediate backup. This meant that in the event of an emergency happening at night we were told that the staff would contact the local police for emergency support. All staff and patients told us they felt safe on the ward and felt that the number of staff was suitable to meet the needs of the patients group.
- During office hours there was adequate cover for medical staff to attend the ward in an emergency. Out of normal office hours the consultants and senior managers operated an on-call rota, which was clearly visible on all the wards.
- Mandatory training in the low secure wards was up to date. This included safeguarding training for adults and children, information governance, physical intervention training, infection control, manual handling, health and safety, basic food hygiene, equality and diversity, first aid and use of the defibrillator, Mental Capacity Act and Deprivation of Liberty, dementia and mental health disorder training and training in relational security. All of these training courses were captured on the ward training schedules which were available to all ward managers. Training was managed with the support of the education department in the hospital.
- Information provided to us before our inspection by the provider indicated that mandatory training levels were above 75%, apart from in the areas of information governance and "Prevent", which is a training to support staff to ensure vulnerable people are not radicalised. When we reviewed the training figures for the low secure wards we could see that only five staff were out of date with their information governance training, and this had already been addressed by the ward managers.

Assessing and managing risk to patients and staff

- We reviewed 16 patient care and treatment records which were held electronically on a system called Care Notes. We saw clear evidence that all patients were risk assessed on admission and had up to date risk assessments which were linked to their care plans. The service used the detailed Historical Clinical Risk

Management tool (HCR-20) which was updated regularly at ward meetings and CPA meetings. This meant that by looking at the past history of risk and patients' current behaviour, risk was being regularly reviewed and care plans were put in place with the patient to minimise the risk happening again.

- The risk assessment also covered issues relating to the physical health care for patients. This was important because of the age range and range of physical health care issues of the patients being supported. We saw good evidence that the National Early Warning Score (NEWS) system for physical health care was working well, with the patients receiving regular observations, and appropriate actions were taken as a result of this work.
- There were blanket restrictions in place but these were mostly clinically appropriate for the secure services environment.
- Internet access was available in the occupational therapy area if it was risk assessed as appropriate for a patient's needs.
- There was a designated smoking area outside the garden. However patients had restricted smoking times. The patients we spoke with did not seem concerned about this.
- Restrictions included access to the outside garden space. However, the service was mindful of the Mental Health Act Code of Practice in relation to blanket restrictions. Restrictions were relaxed, on an individual basis, for patients who had been assessed not to need that level of security without compromising safety or security. In addition, all staff we spoke with were aware of reducing restrictive practices when possible.
- The hospital had a policy on the management of patient observations and the wards followed this. There was a planned system for ensuring that all patients were allocated individual staff members to observe them on a shift-by-shift rotation.
- All the staff we interviewed told us that restraint was only ever used as a last resort. They told us that de-escalation techniques would always be employed prior to using physical intervention techniques. Data from the hospital showed that across the low secure wards restraint had been used on 30 occasions in the last six months and this involved seven patients. None of the restraints involved use of the prone position as the hospital operated a policy of no prone restraint.
- All staff undertook adult and child safeguarding training as part of their mandatory training. We reviewed hospital data which showed that 98% of staff in the St Magnus Hospital had undertaken this training. All staff we spoke with were clear about their safeguarding responsibilities and knew how to identify and make a safeguarding referral within office hours and during the evening and weekend. Staff were able to identify their local safeguarding leads and knew how to seek support if they needed it.
- The ward had a comprehensive process for the management of restricted items. These were items which may affect the safety on the ward, for example, razors and illicit substances. There was an information pack available for patients when they were first admitted onto the wards and this clearly detailed which items were restricted. In addition to this, all visitors to the low secure service were asked to read and sign a document which clearly identified all items not able to be brought onto the wards, to raise awareness of restricted items. This process was managed by the staff allocated to the 24 hour reception airlock area.
- When new patients arrived at the low secure wards there was a policy in place to show the process for checking in all property before it came onto the wards to ensure any restricted items could be removed safely.
- The hospital had a room in the reception area that could be used to support safely children visiting the service and there was a visible policy and procedure in place to ensure that staff knew how to manage this process.
- We reviewed 24 sets of patient medication records. We observed good medication management at the hospital. Safe but flexible dispensing was provided so there were no institutionalised practices such as patients queuing for their medication. Managers had a system in place to monitor reported medication and administration errors. This was supported by regular pharmacy audits which meant that incidents were recorded and analysed, with actions set, so that staff could minimise the risk of reoccurrence.
- Patient allergies were clearly recorded. The prescribing of "as required" (PRN) medication and sleep medication was regularly reviewed by the clinical team. There was minimal use of PRN medication observed when we reviewed the medication cards on all wards.

Track record on safety

Outstanding ☆

Forensic inpatient/secure wards

- There were no serious incidents reported for the low secure hospital in the past 12 months. The ward managers were aware of recent incidents that had happened elsewhere in the hospital that had affected patient care and had fed this back through the staff team meetings. This ensured that all staff were aware of issues that were affecting other inpatient sites in the hospital. For example, on Willow Ward a medication had been incorrectly prescribed on a medication card, but the correct medication had been ordered and administered by the nursing team. Following group nursing supervision, a weekly medication audit had been implemented, specifically checking what was in the medication cupboard matched the prescriptions and this was now documented.

Reporting incidents and learning from when things go wrong

- There was a governance framework in place which encouraged and supported staff to report incidents. All staff were able to explain confidently to us how they reported incidents using the paper-based system and staff were aware they would soon be moving to an electronic system when the training had been rolled out.
- Managers demonstrated how they reviewed incident reporting in their teams. We saw that, following incidents, investigations and analysis had taken place and the learning had been shared with staff. All the nursing staff we spoke with felt confident using the incident reporting system. Staff were able to explain how learning from incidents was shared in team meetings, emails and staff newsletters.
- We saw evidence that staff were open and transparent with patients when things had gone wrong. We were told that a patient had missed a hospital appointment because staff were unable to arrange enough cover to facilitate the leave. The patient told us that he had been informed immediately and was happy with the explanation.
- We saw that the service listened to staff and patient feedback and made changes to the way the service was delivered. Examples of changes included alterations to patient menus and the inclusion of additional patient activities.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed 16 sets of care plans and found that care was regularly assessed; care plans were documented and reflected the individual needs of the patients.
- Most of the care plans were holistic and detailed. Care plans were reviewed and updated regularly by staff. Care plans showed good evidence of involving patients in their care. For example, we saw care plans to assist a patient with anxiety and hearing distressing voices. These care plans were specifically tailored to address the voices they were hearing, which showed their individual care needs were being identified and supported. The patients' views had also been sought throughout the plan of care. The plans included recovery goals and aims for the future, which demonstrated the plans were recovery orientated. All the care plans we reviewed were updated at least on a monthly basis.
- All patients received a comprehensive physical health check by the speciality doctor on admission. We saw evidence that patients who needed additional physical healthcare were receiving it, with appropriate referral being made when required to the physiotherapy and speech and language professionals.
- The care records were stored on an electronic care planning system called Care Notes which could only be accessed by staff. This meant that patients' confidential care planning information was available in an accessible format. However, not all staff were able to access this system, therefore Oak Ward and Willow Ward kept up to date paper copies of the care plans so all staff could read them. Sycamore Ward did not follow this process.

Best practice in treatment and care

- Staff were using the "My Shared Pathway" care planning system in place for all patients. My shared pathway is a collaborative approach to supporting and developing care which keeps the patient's perspective the focus of the care.

- Psychological input was varied across the wards. At the time of the inspection there was one psychologist in post and no psychology-led groups were running. There was individual work being carried out on a referral basis and the hospital was using a psychologist from outside the hospital on a service level agreement to ensure that all diagnostic formulation work was happening.
- Assessments took place using nationally recognised tools including the "Health of the Nation Outcome Scales" and HCR-20 which were regularly updated at clinical review and CPA meetings. Occupational therapy staff used the model of human occupation tool. This is an occupation based model that looks at why and how people are motivated to carry out an activity.
- Staff were actively involved in clinical audit on the ward. This included medication monitoring audits monitoring the use of covert medication, security audits, deep cleaning audits, infection control audits and reporting back on the NHS safety thermometer (an NHS measurement tool for improving safety).

Skilled staff to deliver care

- The low secure services employed a team that consisted of nursing staff, psychiatry, occupational therapists, psychologist, physiotherapist, speech and language therapy and pharmacy input on a regular basis. In addition there were domestic staff and administration support based at the service.
- In the 12 months prior to the inspection, 94% of the care staff in the low secure service had received an appraisal.
- The staff had a monthly reflective practice session, which was a form of group supervision, as part of their team meeting agenda. All staff had six-weekly management supervision. The staff felt that this was suitable to their needs.

Multidisciplinary and inter-agency team work

- The wards had twice weekly ward rounds attended by the whole clinical team. Patients were seen every two weeks, with the flexibility of being seen more frequently if their level of risk escalated. The meetings were comprehensively structured and minutes of the meetings were detailed and covered all aspects of the patient's mental and physical care and treatment. All the separate disciplines attending provided a report of the patient's progress and future plans.
- New staff had both a hospital wide and local induction programme prior to working on the ward. This meant when they started on the ward they had all their mandatory training and were well orientated to the ward environment, with a comprehensive checklist completed with their mentor.
- Staff told us that they felt performance issues would be dealt with promptly via the line management structure. The managers felt supported by the human resources (HR) and administration teams because information was made available to them regarding sickness levels when they needed it and there were hospital policies to guide them. Staff also told us they felt well supported by the general manager when dealing with HR and performance issues.

Adherence to the Mental Health Act 1983and the MHA Code of Practice

- Staff demonstrated a good knowledge and understanding of the Mental Health Act and they told us they had accessed training through the hospital during their induction. However, when we looked at training records we could see that this training was not mandatory and we were not able to review the number of staff that had completed this training.
- We saw all of the sets of medication cards had copies of consent to treatment forms appropriately attached.
- We saw good evidence of a full and thorough system for checking that section 132 rights were regularly discussed with patients and this was recorded on the Care Notes system.
- Patients had access to generic advocacy, independent mental health advocates and independent mental capacity advocates. Records showed that patients were informed of their rights of appeal against their detention under the MHA.
- Patients had access to mental health review tribunals and hospital managers' meetings.
- Staff were aware of the MHA Code of Practice and their responsibilities. The hospital employed a Mental Health Act administrator whom staff could access for advice and support when needed.
- There was information available on the notice boards on the wards regarding the relevant sections of the

Mental Health Act (MHA) that applied to the particular patient group and how to complain to the CQC in relation to their detention and treatment. Willow Ward also had folders available in each of the patients' bedrooms with their individual care plans and any relevant information leaflets relating to the patients' particular sections of the MHA. There was also information relating to what should happen if a patient were to be discharged from the MHA whilst they stayed at the hospital in relation to their rights to leave the ward. This was not posted on the door to the wards but it was available on a notice board nearby.

Good practice in applying the Mental Capacity Act 2005 (MCA)

- The staff demonstrated a good awareness of the MCA and the guiding principles. They were aware of how the MCA impacted on the patient group and described how the MCA could help when supporting a patient in any decision making process, such as how to support a patient to manage their finances. We saw mental capacity assessments regularly discussed in the minutes of the multidisciplinary meetings in relation to physical health treatments that were available to the patients.
- The staff told us they received regular updates and training in the MCA. Staff knew how to access the MCA policy and additional information about the act on the hospitals' intranet. The training records indicated that 82% of St Magnus Hospital had completed MCA training
- Staff discussed mental capacity in clinical reviews and recorded this throughout care and treatment records. Staff were aware when mental capacity assessments had taken place and where to locate them.
- All patients within the service were detained under the Mental Health Act and there were no DoLS applications required.

Are forensic inpatient/secure wards caring?

Outstanding ☆

Kindness, dignity, respect and support

- We observed extremely positive and caring interactions between the staff and the patients. Staff were always courteous and responsive to patients' requests. All staff in the patient areas were actively engaged with the patients, either speaking with them or encouraging them to take part in ward–based or external activities. Staff had successfully and sensitively formed therapeutic relationships with the patients in their care, some of whom were reluctant to interact due to their illness.
- Staff expressed a caring approach when they were talking about the patient group and it was clear there was an understanding of the patients' individual presenting issues and how best to support them on a daily basis. On Willow Ward we observed a patient become disturbed whilst having a difficult discussion around the review of his medication. The staff were extremely caring and supportive, and demonstrated compassion throughout this interaction.
- All of the patients we spoke to were very positive about the support and care they received from the staff team at the hospital. Patients felt there were always staff available to meet their needs. This was also echoed by the family members we spoke with during the inspection who identified that their relatives were safe and well cared for within the hospital. One carer reported that their relative had been cared for in numerous services previously, and that because of the staff at St Magnus hospital, this was by far the best environment for meeting their relatives' care needs.
- The nine CQC comment cards stated that patients felt safe and peaceful on the unit. There were repeated comments that patients felt that the staff were courteous, treated them with dignity and were doing a good job in supporting their needs.

The involvement of people in the care they receive

- The low secure service had a clear and well-structured introduction pack to the wards which covered all the information necessary to support someone new to the secure environment. The pack identified the key members of the team and the treatments available for patients while they were resident at the hospital. Some patients commented that this had been very helpful to them
- When we discussed care plans with the patients, we found they were all aware of their treatment goals and they had discussed their goals with both their

consultant and primary nurse. There was evidence in the care plans that this was documented and planning goals were orientated wherever possible towards recovery to enable move-on to less restrictive environments.

- Patients reported that their preferences in general were taken into account, but sometimes felt their medication was decided for them. However, patients reported that when medication was decided upon, a clinician sat down with them and discussed why that medication had been prescribed and what the perceived benefits of it were.
- Patients were able to consult with any member of staff around their medication and any possible side-effects they may encounter, and were provided with information about the therapeutic benefits and potential side-effects of the medication.
- The hospital held daily meetings with the patients chaired by the OT department to gather patients' views about what was happening on the ward that day. We saw minutes of these meetings displayed on the different wards, and patients told us they were able to read these minutes if they wished. We observed these meetings in progress. Staff were respectful of patients during the meeting and encouraged them all to contribute to influence the planned events of the day.
- Mood music had been introduced to the wards, energetic music was played during times of activity and more relaxing music was played at meal times. Some patients had their own music play lists that they used for calming purposes when agitated.
- Ward staff were knowledgeable about patient interests and assisted some patients to pursue their hobbies which on occasions involved external visits being arranged.
- A carer's support group was in operation to provide advice and enabled carers to raise any issues or concerns. Carers reported being involved in all decisions regarding periods of home leave. Carers were invited to attend training events at the in-house education department, for example dementia awareness training.
- Ward teams followed a protocol for responding to carers when their relative did not consent to their involvement. This was managed by the social work department through multidisciplinary team meeting to achieve a balance between patient wishes and information from carers that could be useful in patients' treatment.
- Patients had access to both an independent mental health advocacy service and an independent mental capacity advocacy service which were both well used. There were photographs of the representatives and information available on how to access the advocacy organisations on the notice boards, and in the introduction packs. The advocates we spoke with had assisted patients by attending multidisciplinary meetings with them and expressed their views for them when requested to do so.
- A patient satisfaction survey was carried out earlier in the year. The results were an improvement on the previous year's satisfaction survey. Most patients surveyed reported that staff treated them with dignity and respect and were caring towards them.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- In the six months prior to the inspection, on average, 97% of the beds on the low secure wards were occupied by patients. The average length of patient stay in the low secure services in the 12 months prior to the inspection was 716 days.
- Patients were not moved between wards during an admission for non-clinical reasons. When patients were moved, this occurred at an appropriate time of day. Staff told us that if a patient required intensive psychiatric nursing care, a bed could be located on a local NHS psychiatric intensive care unit ward.
- Data provided by the hospital showed that between 1 January 2016 and 31 October 2017 there were no delayed patient discharges from the low secure wards.

The facilities promote recovery, comfort, dignity and confidentiality

- The wards had well-stocked drinks stations to enable access to hot and cold drinks and snack items. These areas were accessible to the patients 24 hours a day.

Patients were able to keep their own food items in the kitchens on the wards in clearly labelled boxes but required staff assistance to access these items as they were in a staff-only area.

- All of the patients were happy with the food cooked on site by the kitchen staff and all cultural and religious dietary requirements could be met. The patients were complimentary regarding the kitchen's ability to meet their individual food choices.
- The hospital had multiple occupational therapy spaces which were well used by the patient group. These included a skills kitchen, a well-appointed sensory room and a gym with modern equipment.
- A therapeutic timetable was available for the patients to access on the wall on all three of the wards. This timetable was not individually tailored to the patients' needs but was an overall plan of activities available during the course of the working week, Monday to Friday. More relaxed activities were planned for the weekends for example, group walks or group meals. When we asked on all wards what individualised activity plans were completed with the patients, we received an inconsistent response. Two of the patients had timetables in their rooms and three of the patients had copies of their individual timetable in their MHA file in the staff office. From speaking to the patients and staff it was not clear what individualised activity work was happening across the wards.
- The wards had access to a quiet room on the ground floor area where patients could meet with their visitors. This room was well appointed and suitable for child visits, with a robust unit plan put into place, co-ordinated by the social workers.
- There were facilities for patients to make phone calls in privacy on the wards, although it was noted that these were not suitable to make private phone calls as it was a wall-mounted speaker phone. When we asked the staff, they told us there was an office phone available for patients should they need to make personal calls.
- There was a small enclosed garden area with a smoking shelter accessed via the occupational therapy area. In addition to this, if patients had suitable leave arrangements in place, there was a wooded wildlife garden area accessed through a set of anti-dash gates outside of the perimeter of the low secure service. This meant that patients supported under criminal sections of the MHA could increase their leave but remain in a safe environment. Patients were encouraged to become involved in maintaining their garden space and we observed the grounds were well maintained.

Meeting the needs of all people who use the service

- Patients spoke positively about their regular contact with the chaplaincy service. The chaplain visited the service on a weekly basis or more frequently if required. The hospital had a multi-faith room with multiple religious texts available from reception. Contact details for representatives from different faiths were available. The chaplain facilitated this contact and the patients and staff all spoke highly of their input.
- Information was available in other languages if needed. Interpreters were used if necessary and the staff were aware of the process for arranging this service. This was not regularly used owing to the current ethnic mix of the local population.

Listening to and learning from concerns and complaints

- Staff supported patients to complain and helped them to resolve complaints. Details of the complaints process, the local "Speaking Up" guardian and CQC were visible on the ward notice boards.
- Hospital data showed that there were four complaints received for the low secure service in the preceding 12 months. Of these four, one complaint was upheld and the service formally apologised to the patient and resolved the matter with the patient's involvement.

Are forensic inpatient/secure wards well-led?

Outstanding ☆

Vision and values

- Staff we spoke with felt that the operational objectives of the hospital which were centred around the provision of excellent care, were extremely positive and told us they felt connected to these objectives and were also involved with the local developments of the hospital.

Forensic inpatient/secure wards

- The staff were aware of the senior management structure and knew whom to contact if there was a particular issue with safeguarding, facilities or human resource issues. The hospital general manager had a visible presence across the unit and the staff told us they felt that the hospital had a stable management structure. Staff felt that the management team were more of a family and nurtured and supported the staff to progress within their roles.

Good governance

- Data provided by the hospital showed that mandatory training in St Magnus Hospital, including the low secure services, was 83%. The ward managers had identified the reasons for their shortfall and were addressing them in co-ordination with the education department. The shortfalls were due to a recent intake of new staff who were in the process of undertaking their mandatory training and the recent introduction of additional mandatory training.
- The wards were monitored using a set of "weekly returns" to measure performance in areas such as how much leave was offered to the patients, supervision rates, return to work and sickness figures and security checks. In addition to this, information was collected in an NHS safety thermometer "heat map" dashboard. This dashboard collected data around areas such as infection control, ulcers and pressure sores, and deep vein thrombosis.
- The ward managers had autonomy to run their wards. The nurse in charge on each shift could increase staffing levels if they felt this was warranted due to increased patient need. There was a clear pathway for this through the general manager and all staff said they were well supported by the hospital manager and other senior staff in the event this was required.
- Systems were in place for sharing information with staff around lessons learned. Nurse meetings were held where information was cascaded between the nurses and then discussed in the ward staff reflective meetings.

Leadership, morale and staff engagement

- Staff morale was very good and staff said they worked in happy teams. We observed strong local leadership across the wards, which staff and patients confirmed. Staff said they felt supported by their colleagues and held them in positive regard. They were enthusiastic about their roles and thought stress levels were healthy and manageable.
- There were low levels of sickness absence in all the services. Staff expressed how much they enjoyed their work and the therapeutic relationships they built with patients. Staff were positive and optimistic about patients, and this was evident in the interactions we observed across all three wards.
- Staff knew the whistleblowing process and said they would be able to raise concerns if the need arose, and were encouraged and supported to do so without fear of victimisation.
- There was a very low turnover of staff within the low secure services and we saw evidence of good team working whilst speaking to staff and reviewing team meeting minutes.
- There were many opportunities for staff development and the culture of "grow your own" nurses was evident within several of the wards where support workers were being developed to undertake their nurse training. The Skills for Care training system was also evident and support workers were supported to engage with this learning opportunity with the support of the education department.

Commitment to quality improvement and innovation

- The low secure service was a member of the Quality Network for Forensic Mental Health Services (Royal College of Psychiatrists) and took part in the annual peer review process. The last peer review took place on 4 April 2017. The peer review report found that the low secure service met 90% of the standards and was in the top 30% for secure hospitals nationally. Staff visited other low secure services around the country and benchmarked those services against a set of criteria and key performance indicators. The aim is to improve the quality of the service they are visiting but it also enabled the service to identify areas that work well and bring those ideas back to St Magnus Hospital.
- The service was involved in national smoking cessation work and was committed to becoming a smoke-free hospital. The hospital was piloting the use of electronic cigarettes in the hospital with the view that this would be rolled out across the low secure service.

Outstanding ☆

Forensic inpatient/secure wards

- The low secure service supported the role of associate nurses within the hospital. The nursing associate is a health care role the Department of Health has introduced in England. The role is designed to bridge the gap between health care assistants and registered nurses. This meant that the hospital was taking steps to upskill its workforce in the face of the current perceived national shortage of nurses.

Outstanding ☆

Wards for older people with mental health problems

Safe	Good
Effective	Good
Caring	Outstanding ☆
Responsive	Good
Well-led	Outstanding ☆

Are wards for older people with mental health problems safe?

Good

Safe and clean environment

- All of the wards were designed to promote observation of the patient group. Nurse stations were situated centrally to the wards with large viewing windows onto the lounges and dining areas. Closed circuit television cameras were installed on all wards and communal areas. These were not constantly observed but were used mainly to review incidents that may lead to safeguarding alerts being raised for this vulnerable group of patients. Convex mirrors were used to enable improved observation of potential ward blind-spots. Not all bedroom doors had viewing panels. Staff performed routine observational checks of all patients at intervals agreed by the ward multidisciplinary team.
- Ligature risk assessments were completed annually. The ligature risk assessments had been completed on each ward by the ward manager and the clinical governance lead. Each room or area had been assessed and deemed either compliant or partially compliant when compared to the template room criteria that formed part of the ligature risk assessment policy. Where a room was assessed as partially compliant, outstanding ligature risk items were identified and mitigated through individual patient risk assessments and regular room checks.
- All of the wards for this service were male only. All bedrooms had en-suite bathrooms with showers. Bathrooms with baths were available on each of the wards.
- Each ward had a designated clinic room area that was kept clean and tidy. Emergency equipment was readily available in the form of a grab-bag. Emergency equipment was checked weekly by staff who signed to state they had completed the checks. All equipment listed as part of the emergency equipment was in date. Emergency drugs were checked and found to be in date. The visiting pharmacist checked the emergency drugs as part of their fortnightly audit. Emergency drugs that were due to expire in the near future were highlighted.
- There were no seclusion facilities on site. Patients were, however, secluded in their bedrooms on rare occasions. The senior management team had developed a seclusion policy for the occasions when patients were asked to spend time in their rooms, or were escorted to their rooms, due to disturbed behaviour to ensure the safety of other patients. The policy acknowledged that this practice constituted seclusion, but did not consider it appropriate to use a seclusion room owing to the nature of the patients' presentations, which included cognitive impairment and physical health conditions. Seclusion was used for brief periods only to ensure that the risks posed by severe behavioural disturbances were managed proportionately and in the least restrictive manner.
- Ward areas across all wards were exceptionally clean, furnishings were to a very high standard and patients had a range of lounge furniture to use dependent on physical health care needs. All environments smelt

pleasant and fragrant. Visitors' rooms were available off each ward and were furnished to a very high standard. Indoor garden rooms and garden space were also well maintained.

- We observed staff adhering to infection control principles. We saw staff washing their hands prior to and after handling patients, assisting with meals and dispensing medication. The infection prevention and control policy was comprehensive. An infection control committee, chaired by the lead nurse for infection control, was held quarterly and attended by the lead tutor for infection control from the in-house education department. A recent case of a patient admitted with methicillin resistant staphylococcus aureus (MRSA) had been successfully contained and resolved. Housekeeping staff had access to an anti-bacterial compressed cleaner used to eliminate harmful bacteria found in bodily fluids.
- All equipment that we saw used to assist with patient care was clean and well maintained. Clean stickers were applied and equipment date checks were visible.
- We spoke with the head of housekeeping and looked over cleaning rotas. These showed that cleaning had been undertaken daily and more thorough deep cleans completed fortnightly. In addition, ward staff could contact housekeeping for additional cleaning as required. Each ward had a detailed description of both a standard clean and a deep clean. As some of the cleaning staff had limited English, an information guide was available in six languages.
- Environmental risk audits were conducted daily on each ward, completed by lead nurses from neighbouring wards. The audits assessed the general appearance of the wards and identified issues of safety and cleanliness.
- Panic alarms and nurse call buttons were wall-mounted and available in each room and communal area. Inspection staff tested these on one of the wards; there was a good response. The alarm required re-setting at point of activation.
- We checked procedures in the event of a fire. The wards were free from fire hazards and there were clear evacuation paths in all areas. The fire exits were clear, signposted and accessible. Staff were aware of the protocol for emergency procedures. Each ward had a list of patient names with details of how they would be moved in the event of a fire.
- We reviewed records and saw that fire checks, drills and training had been completed. The maintenance records demonstrated a quick response to reported issues.

Safe staffing

- The establishment levels for qualified staffing for this core service were 22. There were no qualified nursing vacancies. The establishment levels for support workers and senior support workers were 52. There were no support worker vacancies.
- The provider had a nursing bank for staff wanting to work extra shifts. This was used in preference to agency nurses. The number of shifts covered by bank or agency in a three month period up to the end of August 2017 was 477. A large proportion of these additional shifts were to cover extra-duty nursing for people receiving in-patient care at local general hospitals. Also the extra shifts provided an additional resource to Cowdray Ward which was functioning as a high-dependency nursing unit at the time of our inspection. No shifts over the same three-month period were left uncovered.
- The sickness rate was below one percent (0.6%). There had been a turnover of 14 substantive staff members in the year to the end of August 2017.
- The number and grade of nurse required for each ward shift was estimated by a tool developed by the hospital's quality improvement committee. We reviewed previous duty rotas which showed the number of nurses on each shift matched or exceeded the required numbers of qualified nurses and support workers.
- Bank staff were used to cover vacancies from sickness and annual leave, and additional nursing duties, for example, one-to-one nursing. Agency nurses were used sparingly. A single nursing agency was used and most of the use was to provide support workers for patients currently receiving care and treatment in a general hospital. When agency staff were used on the wards, requests were made for named staff who had experience of the ward and the patient group. This was evidenced on the duty rotas.
- Ward managers were supernumerary; this meant that they were able to provide leadership to the staff on duty. In addition, ward managers were able to request additional staffing via the site general manager or deputy. Decisions to increase observation levels and additional nursing support were made by the ward multidisciplinary team.

Wards for older people with mental health problems

- Owing to the nature of the patient group, most of the patients remained on the ward and sat in the lounge areas. There was always at least one qualified nurse or a senior support worker with the patients during our periods of observation. The wards had sufficient qualified nurses and support workers to enable named nurses to have regular one-to-one time with patients. Only qualified nurses were named nurses for patients and they were supported by senior support workers.
- There were sufficient staff to ensure escorted leave took place. We noted that some patients required additional encouragement to take their leave. Patients who were physically able were encouraged to take part in an escorted walk in the morning subject to the weather constraints.
- All of the psychiatric medical staff worked exclusively for the hospital and were on site on the wards Monday to Friday during office hours. A GP from the local practice visited the site twice a week. After office hours, one consultant was on call and no more than a half-hour journey away. Most of the identified needs for medical assistance were due to deteriorating physical health or acute physical health conditions. The local on-call GP service had not proven to be sufficiently responsive and flexible to meet needs therefore staff contacted the emergency ambulance service to take patients to the local general hospital.
- Mandatory training was provided by the tutors at the in-house education department. The average mandatory training rate for staff was 86%. There were three areas of training where rates were below 75%: Prevent training (60%), information governance (55%), and non-abusive psychological and physical intervention (NAPPI) training (45%). Prevent training aims to safeguard adults at risk from being radicalised to support terrorism and it is a requirement of all adult education departments to provide this training. It was introduced as a mandatory course along with information governance, in April of 2017. NAPPI training forms part of the hospital's least restrictive practices policy and will replace all other forms of previously taught physical restraint once roll-out has been completed.

Assessing and managing risk to patients and staff

- There were two incidents of seclusion in the six month period up to the end of August 2017, both on Petworth Ward. The incidents involved removing a patient from a communal area to his bedroom, where he was supervised throughout, before returning to the communal area. There were 40 incidents of restraint involving four patients during the same time period. The majority of the restraints (39) took place on Cowdray Ward, the admission and assessment ward. The hospital operated a policy of non-prone restraint.
- We examined 21 sets of electronic patient care records across the four wards. Each record reviewed contained a risk assessment at the time of admission which had been updated for new risks or changes in risk status. The risk assessments covered a number of risk areas and were rated as red, amber or green depending on the extent of the assessed risk. The assessment included risk of violence and aggression, suicide, self-neglect, fire-setting, inappropriate sexualised behaviour and absconsion. Each risk was rated using red, amber or green, which culminated in an overall risk rating. Additional modules were used dependent upon the patients' physical frailty, for example, falls risk assessment, manual handling risk assessment and venous thromboembolism (VTE) risk assessment.
- More formalised risk assessments using the HCR-20 assessment tool had been completed for individuals with a history of violence and aggressive related behaviours. These assessments were completed by the medical staff and were used as they could assist in predicting future potential violence and aggression amongst patients.
- There were blanket restrictions, for example there was no free access to hot drinks for the patients on Cowdray Ward, and access to the internet was restricted. However, we noted that these issues were regularly reviewed, either on an individual basis or at the senior management team meetings. The reasons for restrictions were based upon assessments of risk. Patients who smoked were escorted off the ward together at intervals.
- All patients were subject to detention under the Mental Health Act 1983 or deprivation of liberty safeguards (DoLS) and therefore required permission to leave the wards. Patients were accompanied by staff when outside of the ward areas owing to their presentation or vulnerability.
- Policies and procedures were in place for observation, which was based upon Nursing and Midwifery Council mental health advisory committee guidance. There were four levels of observation, ranging from general

observation (knowing the whereabouts of the patient), to within arm's length. Ward staff were able to show inspection team members the assigned observation levels for each patient. The observation levels took into account an assessment of the environment the patient was in or the activity being undertaken. Most patients had reduced observation levels at night. We saw support workers carrying out observations and recording these appropriately. For some patients, observation levels were increased at meal times as this was an area of known high risk.

- Patients were not routinely searched as most leave from the ward was confined to the garden or grounds area accompanied by members of staff. There was a list of contraband items which included foods or confectionary which could constitute a choking hazard.
- All hospital staff were trained in the management of violence and aggression which included de-escalation techniques, situation containment skills and restraint techniques. The hospital was rolling out NAPPI training. In the interim, staff were practising previously taught methods of restraint if required. Rapid tranquilisation had not been used in the six month period up to the end of August 2017. Seclusion was rarely used and was in accordance with the hospital policy.
- Adult safeguarding training had been completed by 98% of the staff group. The lead social worker was the nominated safeguarding lead for the hospital. Staff were able to describe their roles and responsibilities with regard to the Safeguarding process. The lead social worker reviewed the ward 12 hour reports to identify any potential safeguarding issues. All safeguarding alerts were subsequently raised by the lead social worker to the local authority.
- We inspected each ward clinic facility, reviewed medicines management procedures and observed medication dispensing. Our inspection pharmacist reviewed medication on Cowdray Ward and met with the visiting hospital pharmacist from Ashton's pharmacy to discuss medicines management across the hospital. Covert medications were given in accordance with the covert medicines policy and included up to date capacity assessments. There were no major issues of concern with regard to medicines management.
- Owing to the nature of the patient group, those identified at risk had falls, manual handling and venous thromboembolism risk assessments completed. Comprehensive swallowing and choking risk assessments had been completed by the visiting speech and language therapist for patients deemed at risk.
- Children visited the hospital infrequently. There were child visiting policies in place and appropriate visiting rooms that could be made child-friendly. All children's visits were by arrangement only, overseen by the social work team.

Track record on safety

- There had been one serious incident reported in the six-month period prior to inspection. This was an information governance breach. Confidential patient information was lost and not recovered on an outside hospital visit. Senior managers had introduced secure document folders to transport patient confidential information as a result.
- Other adverse events relating to this patient group included falls and fractures, choking and, more rarely, patient upon patient assault. Owing to the declining physical health of some patients they sometimes needed to be admitted to a local general hospital. Staff from St Magnus Hospital or agency staff were used to provide escorts to these patients throughout their acute hospital admission.
- Safety improvements specific to this client group included use of portable hoists to transfer patients from chair to bathroom or bedroom to prevent handling injuries. Also specific dietary supplements and equipment were identified through swallowing and choking risk assessments.

Reporting incidents and learning from when things go wrong

- Staff were aware of what constituted an incident to be reported and were able to give examples of recent incidents reported. Qualified staff reported incidents directly using a paper form known as an IR1 form. Support workers reported incidents to qualified nurses for onward reporting.
- Duty of candour training was provided during staff induction training. We saw posters on the wards and in other areas outlining the duty of candour process. Ward offices displayed flow charts to assist staff in identifying if incidents met the duty of candour thresholds.
- Staff reported they did not always receive feedback from investigation of incidents, both externally, through the

safeguarding alert processes, and internally, from reported incidents. Managers reported delays in receiving responses from the local authority older people's safeguarding team and difficulties in engagement with the local authority adult Safeguarding team. An electronic incident reporting system had been purchased to replace the IR1 forms.

- Incidents were discussed and recorded by managers at the senior management team meetings, with associated actions. There was evidence of change having been made as a result of feedback. Sealed document wallets were used to transport patient-specific information outside of the hospital and, following feedback from a carer about a step being a potential trip hazard, a small ramp was put in place.
- Ward managers told us that they would conduct staff debriefs following incidents on the wards. If the incident was serious or distressing, other members of the ward multidisciplinary team would be involved. Staff told us of a recent unexpected death of a patient that was upsetting to staff, many of whom had not experienced the death of a patient before. Managers and other staff visited the ward and talked through the incident and comforted distressed staff.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We inspected 21 care records. We found four records that did not include comprehensive assessments to the same standard as other care records. These included incomplete assessments, or parts of the assessment not present, for example, nursing assessments.
- Four care records did not contain details of a full physical health examination on admission. However, physical health care was well provided for as the hospital employed qualified general nurses as well as mental health nurses to deliver care. In addition, the medical staff had good knowledge of patients' physical health conditions and a GP visited the hospital twice a week.
- The care records were regularly updated and were personalised to each patient. They included a full range of problems and needs based on 'My Care Pathway', a tool used to assist staff to assess all areas of care needs. These included for example, risk, safety of self and others, physical health and disability, mental health wellbeing and emotional needs, activities of daily living and communication. Care plans were detailed and tailored to the physical and mental health needs of each patient.
- Care plans were recovery oriented to a realistic extent. Owing to the progressive nature of most of the patients' presentations, the care plans were aimed at maintaining and improving physical and mental health where this was achievable.
- All of the completed information was available to staff. However, only qualified nurses had access to the electronic care records. We were advised this was due to the often sensitive nature of the information held which may have included details of offending behaviours. Support workers had access to paper records which were extensive, included copies of care plans and details of formal do not attempt resuscitation (DNAR) decisions. Co-ordination between the two systems was the responsibility of the ward manager.

Best practice in treatment and care

- Medical staff followed the National Institute for Health and Care Excellence guidelines in the prescribing of medication. Prescription charts demonstrated psychotropic medication reductions, no use of high-dose antipsychotic medication and limited use of 'as required' medication.
- Psychological therapies were available, many of which included socialising with staff to maintain cognitive function. More specialised therapies were available, for example the sex offender treatment programme was being provided at an alternative facility. Positive behaviour support plans were used to manage behavioural symptoms associated with dementia and to manage medication reduction.
- Access to physical health care was readily available and the hospital had a contract with the local GP practice. A GP visited the hospital site twice a week. All new admissions were registered with the GP surgery. The GP visited all wards during their weekly visit and dealt with a range of physical health issues, supported by the ward based associate specialist doctor. Duties included

taking blood samples for monitoring, annual health checks, medication review and referral to specialists as required. The GP had been working at the hospital for three and a half years and described the standard of care that patients received as 'extraordinary'.

- Care plans included assessments of nutrition and hydration. A comprehensive swallowing and nutrition care plan was completed with assessment from a speech and language therapist, as required, who assessed swallowing capabilities and advised on dietary supplements (thickeners) or the need for a pureed diet.
- Rating scales were used and were present in all care records, these included HoNOS 65+ and Katz scales for assessing bathing, toileting, continence, dressing, transferring and feeding. The malnutrition universal screening tool was also used to monitor weight loss, symptoms of acute disease and risk of malnutrition.
- Clinical staff participated in clinical audit, for example care plan, risk assessment and environmental risk audits. The visiting pharmacist completed regular monthly medicines management audit.

Skilled staff to deliver care

- Each ward had its own multidisciplinary team made up of a range of clinical staff which included psychiatrists, social workers, occupational therapists, the ward manager and nurse in charge. In addition a psychologist was employed and a speech and language therapist was contracted to work across the hospital as needed. Additional specific psychology input was bought in as required.
- The staff were appropriately qualified, for example, there was a mix of forensic and older age psychiatrists. The service also had a psychologist who specialised in the care of older people with offending behaviours. Most of the ward managers had progressed from staff nurses at the hospital to their current position. Retention rates were good across all disciplines. The senior management team were experienced professionals, many having worked at the hospital for several years.
- The hospital had an on-site education department which employed three tutors and provided induction for all staff. All support workers had achieved, or were working towards, the Care Certificate. All staff working with patients had post-induction training requirements which included three accredited courses on dementia and training in the application of the national early warning score to monitor physical health change.
- The education department was an accredited awarding body for externally recognised qualifications, for example, diplomas in health and social care. In addition, the department tutors ran study courses, for example, dementia awareness, diabetes and end of life care. Each staff member had an individualised training programme which included both mandatory and additional interest training.
- Additional specialist training was available for staff; the hospital had supported five senior support workers to qualify as associate nurses. One of the consultant psychiatrists attended the neurology centre at Queens Square in London to gain additional experience in neuro-psychiatry.
- Staff received regular clinical and managerial supervision. Supervision and appraisal audits were carried out. The percentage of non-medical staff who had received an appraisal in the previous 12 months was 94%.
- Staff performance was managed initially through a six-month probation period for all new staff. During this period staff were assessed for their communication and nursing skills and only retained as part of the work force if the probationary period was passed successfully. The management of ward-based staff performance was the responsibility of the ward managers. Additional advice, guidance and support was available through the hospital senior managers and the human resources staff member. For senior staff, we were advised that an external reviewer would be engaged to assess current performance and advise on future performance management.

Multidisciplinary and inter-agency team work

- There were a range of clinical and non-clinical multidisciplinary team meetings. Each patient's care was reviewed by the ward team on a monthly basis. We observed a multidisciplinary care programme approach team meeting. This was attended by the ward multidisciplinary team. The external care-co-ordinator was invited but was unable to attend. Despite this, decisions were made about potential types of move-on accommodation that would suit the patient's needs. We also attended two other multidisciplinary team meetings held to review the care and treatment of

patients. Staff had prepared well, gave informative accounts of patient presentations over the past fortnight, reviewed risk and care plans, and made decisions with regard to future care.

- We observed two ward handovers from night shift to day shift. The handovers included an update on all patients (which was compiled on a 12-hour report that was sent to the senior management team) and an allocation of observation duties and day planning.
- Staff outlined difficulties with continued engagement of home treatment teams. We were advised that this was due to the distance the hospital was from the patient's home area or because it did not have sufficient priority, as some patients had been at the hospital for many years and opportunities for return to the home area was unlikely.
- The senior staff team described a productive and helpful relationship with the local authority, with particular regard to the adult and older-adult safeguarding team members. Quarterly meetings were held between the hospital and the local authority. The two visiting GP's from the local practice felt there was very good engagement between the surgery and the hospital.

Adherence to the Mental Health Act 1983 (MHA) and the MHA Code of Practice

- All but five patients were detained under the Mental Health Act (MHA) at the time of our inspection. Detentions were either under part two or part three of the Act. MHA training was covered at staff induction but it was not part of annual mandatory training requirements. However the staff we spoke with had a good understanding of the MHA and the associated MHA Code of Practice. All staff were aware of the requirements for authorising leave and their role and responsibilities as escorts during leave for their patient groups.
- We reviewed all medicine charts. Consent to treatment forms were attached to all medicine charts and copied into the paper care notes folder. We examined the charts of all patients who required either a T2 or a T3 form for treatment authorisation. All were in good order.
- Staff regularly explained their rights to patients subject to detention under the MHA. Staff recorded monthly this had been attempted or achieved. This was also subject to audit by ward managers and the MHA administrator.
- Legal advice and administrative support on the implementation of the MHA was available from the on-site MHA administrator.
- We inspected the detention papers of a sample of patients detained under both part two and part three of the MHA. All detention papers were in good order and stored appropriately, with electronic copies attached to care notes and paper copies in the case file. The original documents were retained by the MHA administrator.
- The MHA administrator reviewed all detention papers on admission and, in addition, we saw that capacity and consent to treatment audits were conducted every six months and section 17 authorisation for leave forms were audited monthly.
- Independent mental health advocacy services were provided by Matrix advocacy services. We saw evidence that they had provided support and guidance to individual patients.

Good practice in applying the Mental Capacity Act 2005 (MCA)

- Five patients were subject to deprivation of liberty safeguards (DoLS) authorisations at the time of our inspection. These were the only five applications made in a six-month period prior to our inspection. All of the applications were for patients on Goodwood Ward.
- Eighty-one percent of staff had received training in the Mental Capacity Act (MCA). The staff we spoke with had a good understanding of the MCA and DoLS and there were policies for both available on each ward.
- Staff were familiar with the MCA due to the nature of the patient group, many of whom had impaired capacity. Capacity to consent was assessed, recorded appropriately and decision specific. Assistance was given to patients by the independent mental capacity advocate, ward staff, social workers and medical staff to make specific decisions before it was assumed that a patient lacked capacity.
- We saw examples of best interest decisions taken on patients' behalf for the use of covert medication and management of finances.
- Advice and support on the MCA and DoLS was available from the on-site MHA administrator.
- The covert medication audit up to June 2017 found that all patients in receipt of covert medication had a capacity assessment and a best interest meeting for decisions to covertly medicate. We observed that

capacity assessments were reviewed every three months. The reviews were recorded in the monthly multidisciplinary team meeting minutes for each patient.

Are wards for older people with mental health problems caring?

Outstanding ☆

Kindness, dignity, respect and support

- We observed staff interacting with patients and with each other during the course of their caring duties. All staff were polite, respectful and demonstrated a caring attitude towards the patients in their care. The ward environments were calm and well-staffed. Staff members anticipated the needs of patients through their knowledge of individuals, and responded to expressed need in a calm and appropriate manner.
- We also observed staff interactions with carers and visiting clinicians which were equally appropriate. All visiting clinicians commented on how caring the staff were and how well cared for the patients were.
- We spoke with nine patients who told us about the care they received. Seven of the patients spoke positively about the care staff and said they felt staff treated them with respect. Patients said that staff were aware of their limitations and responded to their care needs. Patients reported that they felt safe on the wards and that the staff looked after their interests and met their physical health care needs well.
- We received 10 comment cards. Most patients were content with the service they received. One patient liked the garden area, another patient wanted more leave granted, and a third said the hospital was too far away for their family to visit.
- We spoke with five carers of patients from all four wards. All were overwhelmingly positive about the care their relative received. Two carers remarked that their relatives were much happier at St Magnus Hospital than at their previous placement. All carers felt that staff were caring, respectful and appropriate when caring for their relative. One relative remarked how caring the staff were towards them as well. Another said they were very happy with how well informed the family were kept. A third carer felt that St Magnus Hospital was the best place possible for their relative.

The involvement of people in the care they receive

- The patients interviewed who were able to comment on how informed they were on admission, spoke positively about this experience. Carers reported being well informed about their relatives and how they would be treated. Ward staff told us that they encouraged carers to accompany patients when first admitted to the ward.
- All of the care plans reviewed by inspection staff demonstrated that repeated attempts had been made to involve patients in their own care planning and risk assessments. Patients had been offered copies of their care plans in all cases.
- In each room there was a laminated poster entitled 'This is Me'. This detailed information about the patient and included what job they previously did, what hobbies and interests they had, how they presented if agitated or upset, and what methods worked best for consoling individuals if upset. The information had been provided by family members or care staff from previous placements. Staff reported that this information was helpful in engaging patients in conversation and understanding some of their care needs.
- We observed that staff encouraged patients to maintain their independence. Some patients required little input, whilst others were reliant on staff to meet most of their care needs. Some patients were able to access shopping trips and buy some of their own food and snacks.
- Advocacy services were provided by Matrix advocacy services. Advocates visited the wards regularly and assisted patients with, for example, the completion of comment cards so that their views were represented to the CQC inspection team.
- Patients were able to give their views on the service. A patient satisfaction survey was carried out earlier in the year. The results were an improvement on the previous year's satisfaction survey. Most patients surveyed reported that staff treated them with dignity and respect.
- Patients were able to express their views and be involved in decisions about their service, for example, daily group or individual activity planning. In addition,

patients were able to personalise their meal planning within reason. The chef made special efforts to ensure that the food served was what individuals wanted to eat.
- Many of the patients had advance decisions in place which instructed doctors and nurses not to attempt resuscitation should the need arise. These decisions were placed in the front of the paper care notes in the ward offices.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- The average bed occupancy over a six-month period to the end of August 2017 was 98%. Owing to the highly specialised nature of the service, all wards had an average bed occupancy rate above 85%. The average length of stay was 634 days. There were three patients under consideration to transfer to St Magnus Hospital when an appropriate bed became available. Two patients from external placements had recently been deemed inappropriate to transfer.
- As a specialist provider, patients had originated primarily from the South of England, although several patients originated from other parts of the country. There was, therefore, no specific catchment area.
- There was a hospital care pathway for patients with a dedicated admission ward, wards for recovery/ continuing care, and a specialist nursing home on site. Movement tended to be along this pathway for most patients based upon clinical needs. At the time of inspection four patients were being prepared for transfer to other wards within the hospital and three patients were awaiting suitable placements in their area of origin. Trial leave periods were managed subject to the Mental Health Act 1983 requirements. Leave beds remained available until successful discharge had been facilitated.
- Owing to the needs and vulnerabilities of this patient group, discharge planning processes were necessarily lengthy to ensure any potential move-on service could adequately and safely meet the needs of patients.
- Discharges were delayed for a range of procedural or financial reasons. These included care-coordinators not allocated or not engaged in the Care Programme Approach (CPA) process and patients waiting for funding approval.
- In the six-month period up to the end of August 2017 there had been one delayed transfer of care.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had access to spacious, bright and well decorated lounge and dining areas. There was sufficient empty space for patients with symptoms of dementia to walk safely. Patients had access to a very well-equipped therapy area off the ward where some patients practised activities of daily living skills.
- Each ward had equipment necessary to support treatment. Portable hoists were used to transfer less ambulant patients. There were no clinic rooms for patient examination or for blood taking. This was conducted in patients' bedrooms.
- Each ward had a thoughtfully-furnished quiet room where patients met their visitors. Owing to the nature of the service and to protect visitors, all patient visits were conducted in the quiet rooms adjacent to the ward.
- Patients were able to make phone calls in privacy using the ward phone in their bedroom area. Each ward had access to well-appointed secure garden areas and other outside space subject to the Mental Health Act 1983 restrictions on leave. The hospital adjoined a National Trust owned woodland.
- The food was of a very good quality. We visited the kitchen area and spoke with the chef. The kitchen had received a rating of five stars (maximum rating) from the Food Standards Agency inspection team for hygiene and cleanliness. All products were fresh, locally sourced, and prepared and cooked on site by a team of chefs. Patients had a choice of meals. The speech and language therapist worked with the chef to ensure the consistency of meals prepared matched the assessed swallowing ability for each patient.
- Each ward had a kitchen area and patients were able to have snacks and drinks throughout the day or night.

Patients were not able to have free access to hot drinks on Cowdray Ward following a risk assessment of the patient group. This restriction was based on safety grounds and we saw that this was regularly reviewed.

- Patients were able to personalise their bedrooms, for example with photos of themselves when younger or of family members.
- Each en-suite bedroom had a large double wardrobe for the storage of clothes and other personal effects. This remained locked. Patients who had the ability to manage safely their personal effects had a key to their wardrobe and could maintain an optimum level of independence.
- Activities were provided through the week by therapy and activity staff. At weekends activities were provided by ward staff. The activities were mainly group activities. Although patients had individualised activity plans, these consisted of group activities with one or two one-to-one sessions which were used for activities such as a shopping trip. The activity programmes were not individually tailored to the known needs and interests (as in 'This is Me') of individuals.

Meeting the needs of all people who use the service

- Adjustments had been made for people with disabilities. There was lift access to the upper floors and ramp access from the outside of the building. Some of the patients had sight and/or hearing impairments.
- Information leaflets were available in English and some were in easy-read formats. There was access to information on treatments, patients' rights, local services and complaints. We were advised that interpreters or signers could be used if required.
- Dietary needs were well met. The chef received the list of dietary requirements for each ward at the beginning of each week and made the food to order. Requirements included diets for people with diabetes or allergies, or diets for religious or ethnic groups. Food was prepared as pureed, soft or normal diet.
- Each of the visiting rooms adjacent to the wards could be used a multi-faith rooms; copies of the Bible and the Quran, for example, were kept on site. We were also advised that a priest visited the hospital each week.

Listening to and learning from concerns and complaints

- There had been three complaints received for this service in a 12 month period prior to the inspection. Two of these complaints had been upheld. No complaints had been referred to the complaints ombudsman.
- Patients who were able to inform us advised that they knew how to make complaints and received feedback from their complaints.
- Staff understood the complaints policy and processes. Complaint numbers were low. All complaints were submitted to, and discussed at, the monthly senior management team meetings. Minutes from these meetings were examined and demonstrated a multidisciplinary discussion for each complaint, with appointed actions. One external complainant had received an apology from the general manager following a recent visit to the hospital, even though procedure and process had been followed to facilitate the visit.
- Ward managers met weekly to discuss a range of issues with the general manager, including complaints. Staff received feedback from complaints via their ward manager or nurse in charge during supervision. One ward manager described an incident whereby a carer had complained that the step leading out to the garden was a potential trip hazard. This was brought to the attention of the general manager and the step was replaced with a small ramp.

Are wards for older people with mental health problems well-led?

Outstanding ☆

Vision and values

- The organisation's values were centred on maintaining the quality of individualised care provided to their patients. All clinical staff we spoke with identified care-giving as their top priority. All ward managers set and maintained high standards of patient care. There were no specific team objectives other than to meet the physical and mental health needs of the patients in their care.
- Senior staff were routinely present on all of the wards. The general manager visited all of the wards at least daily. The medical director and operations director were also frequent visitors to the wards.

Outstanding ☆

Wards for older people with mental health problems

Good governance

- Systems and processes were embedded well to ensure staff met their mandatory training requirements. The on-site education department delivered and monitored all mandatory training requirements and had established individualised learning plans for clinical staff.
- Managerial and clinical supervision was provided for all clinical staff. Ward managers regularly audited the uptake of supervision and were aware of their responsibilities. The system for appraisals ensured that each staff member had an annual appraisal; copies of the appraisals were found in staff records.
- All wards had a high staff to patient ratio, with ward managers able to request additional staffing as required. There were both qualified mental health and general nurses on the wards to provide clinical expertise, supervision and guidance for support workers.
- Care needs were high within this service. We saw that staff spent the majority of their time on direct care activities.
- The clinical governance committee met quarterly and reviewed outcomes of clinical audits, for example pharmacy, the MHA, the MCA and incidents. Ward managers had clinical audit systems in place to ensure standards were maintained in care plans, risk assessments, medication recording, supervision and appraisal.
- Incident reporting was managed using a paper-based system. An electronic system was due to be introduced and rolled out in the next few months. Incident forms were reviewed by senior managers and discussed at senior manager meetings. The incident feedback loop was not always effective. Some staff generating incident reports stated that they did not always receive feedback following incident reviews, although there were processes in place for learning outcomes to be shared across the whole hospital site.
- The safeguarding, Mental Health Act 1983 and Mental Capacity Act 2005 procedures were clear with identified leads, and managed well.
- Ward mangers had sufficient authority to carry out their role effectively. Administrative support was available if required.
- The hospital risk register had been introduced in the last 12 months. It was reviewed monthly and contained high–level risk items only. Low-level risks were managed at ward level. There were plans in place to expand the risk register to include ward-based risks that met an agreed threshold.

Leadership, morale and staff engagement

- A staff survey completed within the past 12 months showed that 82% of staff were positive about working in the hospital. The top positive issue from the survey was that staff felt respected by managers. The top negative issue was that staff felt a sense of disconnect from the wards to the larger hospital site.
- Sickness and absence rates were low at less than 1%. There were no bullying or harassment cases ongoing and there had not been any in the three month period prior to the inspection.
- Staff were aware of the whistle-blowing process and were encouraged by managers to contact them directly with any concerns. Alternatively staff were able to submit anonymous letters of concern, or approach the recently appointed Freedom to Speak-Up Guardian.
- We held a staff focus group during the inspection which was attended by 25 staff. The outcome was resoundingly positive. Staff attitude towards their job role was extremely positive, focused on individual patient care and ensuring care and routines were flexible and adapted to individual needs. The staff group felt they were encouraged to speak up and were supported in doing so. The staff group praised the work of the training department and spoke of the ethos of involving patients' families and carers in the work that they did.
- We spoke with staff who had been encouraged and motivated, and provided with leadership training to support them in their current roles and preparedness for promotion. Staff felt supported and encouraged by each other and the management team.
- The service had implemented regulations with regard to the duty of candour. Staff were encouraged to report both high and low-level incidents. There was a broad interpretation of incidents that led staff to follow the duty of candour policy. One patient reported that staff apologised if things went wrong. The independent mental health advocate (IMHA) visited the wards twice weekly and took any issues raised by patients to senior

managers. The IMHA reported that the hospital managers responded very quickly and positively to any issues raised, and that there were no issues currently outstanding that had not been addressed.
- Staff informed us that they were actively encouraged to give feedback on the service and felt included in decisions with regard to service change or development.

Commitment to quality improvement and innovation

- Staff at all levels spoke of a culture of learning and improvement. There was a commitment amongst all staff to raise and maintain standards of patient care. Senior clinicians were supported to pursue relevant special interests for example, neuropsychiatry.
- The service did not take part in any national quality improvement programmes.
- Innovative practices were seen with regard to staff retention. These included the development of five senior support workers into associate nurses, the sponsoring of staff to complete their qualified nurse training, and appointing qualified general nurses to the service and supporting their mental health training to become a dual registered nurse. Temporary, subsidised accommodation was also provided and a subsidised transport scheme was available to and from the nearest major city.
- Research-based use of music for this patient group was used. Individual playlists were available for some patients; mood music was also used on the wards. This involved more energetic music during activity times and more relaxing music at supper time.
- The use of 'This Is About Me' laminated posters in patients' bedrooms enabled staff to read brief biographical details about each patient, their interests and hobbies, what triggered agitation, and what calming methods could be used.

Outstanding practice and areas for improvement

Outstanding practice

- Research-based use of music for this patient group was used. Individual playlists were available for some patients; mood music was also used on the wards. This involved more energetic music during activity times and more relaxing music at supper time.
- Carers were involved in the care and treatment of their relatives. The use of 'This Is About Me' laminated posters in patients' bedrooms enabled staff to read brief biographical details about each patient, their interests and hobbies, what triggered agitation, and what calming methods could be used. This information had been provided by patients and their carers.
- St Magnus Hospital had its own education department, providing in-house mandatory training and Care Certificate training. It was accredited to provide a range of health and social care certified courses. Each staff member had an individualised training programme. The department tutors also ran study courses in relevant subjects such as dementia awareness, diabetes and end of life care. Carers were invited to attend hospital training sessions for example, dementia awareness training.
- Staff development and succession planning were embedded within the service. Many staff in senior positions had commenced their healthcare careers at the hospital. Senior support workers were encouraged and supported to become associate nurses or registered mental health nurses. Registered general nurses were supported to undertake additional registered mental health nurse qualifications.
- Temporary, subsidised accommodation was provided on-site for staff. Subsidised transport arrangements were in place to and from the nearest city. Flexible working practices enabled some staff to travel from the north of the country, work their weekly shifts, and stay in temporary accommodation before going home for their days off.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all staff receive feedback from incidents they have raised, to ensure individual learning from incidents can take place.
- The provider should ensure that all physical health and nursing examinations are completed on admission, and recorded in the patient's care notes.
- The provider should consider recording and documenting daily personal alarm tests, to ensure staff or visitors could not be given an alarm that had not been checked as functioning correctly.
- The provider should consider the range of activities offered and ensure these are tailored to the known needs and interests of individual patients.
- The provider should consider the need to include Mental Health Act 1983 training as annual mandatory training.