Lancashire Care NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

Guild Lodge
Guild Park
Whittingham
Preston
PR3 2JH
Tel: 01772 695300
Website: www.lancashirecare.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RW5ED	Guild Lodge	Bleasdale Calder Dutton Elmridge Fairoak Fairsnape Fellside Forest Beck Greenside The Hermitage Langden Mallowdale Marshaw Whinfell	PR3 2JH

Summary of findings

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

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

Where applicable, we have reported on each core service provided by Lancashire Care NHS Foundation Trust and these are brought together to inform our overall judgement of Lancashire Care NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Overall summary

We rated forensic inpatient/secure wards as "requires improvement" because:

The physical environments of Calder, Fairsnape, Greenside and The Hermitage wards needed improvement. There was significant damage to Calder and Greenside wards. On Calder, Fairsnape, Greenside and The Hermitage wards there were ligature risks present. However, there were plans in place to address all of the issues associated with the physical environment and ligature risks, and a programme of work was underway.

Seclusion facilities on Calder, Fairsnape, Greenside wards were poorly equipped.

Bleasdale, Elmridge, Mallowdale, Fellside, Forest Beck, Marshaw, Dutton, Whinfell and Langden wards were in good condition and presented safe, clean and pleasant environments, Fairsnape and Fairoak needed some updating and Calder, Greenside and The Hermitage were in a poor condition. However, we found Greenside and Calder wards were not clean and hygienic.

The trust had legitimately implemented a no smoking policy at Guild Lodge in January 2015. We found this was not consistently applied across the site. We found evidence of patients smoking on wards despite staff enforcing the policy, while others at Guild Lodge were not. This resulted in staff on site dealing with smoking-related incidents differently as some staff allowed patients to bring smoking materials into the site while others did not. In addition staff on wards told us where the ban was being enforced there had been an increase in incidents as a direct result of the ban.

Patients were treated with dignity, respect and kindness and staff were dedicated and enthusiastic about involving patients in their care, However we received mixed comments from patients we spoke with and from comment cards we received gave mixed views about patients' experience of dignity, respect and support. Concerns were raised about escorted leave and activities being cancelled, understaffing, unsafe patient mix on some wards, and the poor quality of food. Patients also complained about the no smoking policy, blanket restrictions on mobile technology and disrupted sleep owing to the practice of 15 minute observations at night for all patients in medium secure wards. Complaints during a 12 month period prior to the inspection showed patients had complained about issues including concerns about safety on wards, availability and quality of food, cancellation of leave, and staff behaviour.

Patients did not have privacy for phone calls as public phones were located in communal areas and not all had a hood.

Patients and staff raised concerns about the quality of food and special diets were not easy to access. Religious needs were not always met in a timely manner even though there were spiritual care facilities on site.

Patients frequently experienced cancellations to escorted leave and activities. Staff were regularly called away to the phase one services to deal with incidents, so were not available to patients to support leave or engage in activities.

There was no learning from complaints about the food and cancellation of activities and leave. This resulted in patients raising concerns with us during the inspection.

All patients were subjected to searches on return from off-site leave owing to smoking-related risks and a recent serious incident. However, this policy would not be appropriate for low secure or step-down services without individual risk assessment.

Patients complained about the blanket restrictions in place on access to mobile devices, social media and communication technology (IPADs, computers, mobile phones). Patients described their need to make contact with family and friends. Patients on Fellside and Forest Beck step-down wards were permitted to have non-SMART mobile phones.

Because of the rural location of Guild Lodge local public transport was limited. Staff often booked the trust's pool cars to support patients with off-site activities and leave. However, when the cars were diverted for use elsewhere, such as medical appointments, activities were cancelled.

Activity plans on Dutton ward showed patients received below 25 hours per week of meaningful activity. Leaving the site boundary to smoke was regarded as an activity. However, on other wards patients were offered between

Summary of findings

13 and 21 hours of meaningful activity per week. The notes of the service user group meetings showed cancelled activities and leave were common complaints. The occupational therapy team said the main reason for activities being cancelled was transport being diverted at the last minute for use at appointments. Staff told us they would try to re-arrange leave when activities were cancelled, however, in the women's service, the occupational therapist helped to cover leave and activities when there were staff shortages.

Review of meeting notes on Marshaw ward confirmed that leave was cancelled owing to staffing issues. Staff on Marshaw ward said they did not have time to facilitate activities, and activities were inconsistent and not structured. On Fellside, Elmridge and Mallowdale wards, activities and leave were frequently cancelled because staff were diverted to other wards in response to incidents or understaffing.

There were good religious facilities on site and religious leaders could be invited to Guild Lodge upon request. For example, an Imam often visited a Muslim patient. However, access to religious facilities was inconsistent. Two patients said they found it difficult to access religious services. In one case, the lack of response to a patient's request led to a serious incident.

Patients and staff on most wards raised concerns about the food describing it as poor quality. There was dissatisfaction with the two day advance ordering process, especially for patients with acquired brain injury. While catering for special diets was provided, for example, vegetarian, halal, and altered consistency, it was described as 'hard to get' and 'same'. An example was given of a service user receiving the same halal microwave meal every day.

Patients in Guild Lodge made 65 complaints in the twelve months prior to the inspection, which was the highest number of complaints throughout the trust. Patients made complaints about a wide range of issues including concerns about safety on wards, availability and quality of food, cancellation of leave, and staff behaviour. Complaints were fully considered. Outcomes included written apologies to patients, improving patients' understanding of policies and practices, adding issues and outcomes to Guild Lodge's share the learning document, improving information, guidance and publicity, and supervision of staff.

In September 2013, the CQC asked the trust to review the environment of the seclusion room shared by Whinfell and Bleasdale wards. The building works had finally commenced to address these concerns at the time of our inspection. At this inspection, we noted delays in responding to maintenance and cleanliness on the Calder, Greenside and The Hermitage wards.

Security systems and processes for the site were good and staff had a good understanding of safeguarding policies and practice.

There were comprehensive assessments and care plans in place, with a strong focus on good physical health care needs, with good access to a range of health services such as GP, specialist diabetic nurse, and podiatrist.

Staff understood their responsibilities under the Mental Health Act and patients were regularly informed of their rights. Guild Lodge was utilising recovery-based models of care such as My Shared Pathway and Recovery Star, though implementation was inconsistent across the wards.

There were good multi-disciplinary working practices in place on most wards and medicines management was in line with good practice. The women's service was operating a gender-informed model of care, which was regarded positively by patients and staff.

There was a range of facilities and activities available on and off-site, although access was limited when there were staffing shortages. There were ward-based activities and access to outside space for most wards.

We found examples of wards managed by committed managers with strong visions and values for example, the women's service operated a gender-based model of care, and the men's rehabilitation/step down ward (Fellside) strongly promoted hope and independence to patients. Management were accessible and supportive but this was not consistent across all services.

All wards received performance reports showing a range of data including compliance with mandatory training, sickness absence levels, and complaints.

The service was working in partnership with UCLAN (The University of Central Lancashire) on research into the involvement of patients and families in violence prevention and management.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The physical environment of Calder, Fairsnape, Greenside and Hermitage wards needed improvement.
- There was significant damage to the fabric of Calder and Greenside wards.
- There were ligature risks on Calder, Fairsnape, Greenside and Hermitage wards.
- Seclusion facilities on Calder, Fairsnape, Greenside wards were poorly equipped.
- Calder, Greenside and The Hermitage were in a poor condition and did not provide a safe environment.
- Greenside and Calder wards were not clean and hygienic.
- The trust had legitimately implemented a no smoking policy at Guild Lodge in January 2015 but this was not consistently applied across the site.

However, some wards were in good condition and presented safe, clean and pleasant environments. Security systems and processes for the site were good. Staff had a good understanding of safeguarding policies and practice. There were some plans in place to address some of the issues associated with the physical environment and ligature risks. Medicines management was in line with good practice with few exceptions.

Are services effective?

Good

We rated effective as good because:

- There were comprehensive assessments and care plans in place.
- There was a strong focus on physical health care needs and there was good access to a range of health services such as GP, specialist diabetic nurse, and podiatrist.
- Staff had a good understanding of their responsibilities under the Mental Health Act and patients were regularly informed of their rights.
- Guild Lodge was utilising recovery-based models of care such as my shared pathway and recovery star although implementation was inconsistent across the wards.
- There were good multi-disciplinary working practices in place on most wards.
- The women's service was operating a gender-informed model of care, which was regarded positively by staff and patients.

Summary of findings

Are services caring?

Good

We rated caring as good because:

- Patients were treated with dignity, respect and kindness.
- The staff was dedicated and enthusiastic about patient care.
- Staff knew patients and their needs well.
- There was good interaction between patients and staff. There were lots of examples of patients' involvement in their own care and in wider service developments and improvements.

However, concerns were raised about escorted leave and activities being cancelled, understaffing, unsafe patient mix on some wards, and the poor quality of food. Patients also complained about the no smoking policy, blanket restrictions on mobile technology and disrupted sleep owing to the practice of 15 minute night observations for all patients in medium secure wards. Complaints during a 12 month period prior to the inspection showed patients had complained about issues including concerns about safety on wards, availability and quality of food, cancellation of leave, and staff behaviour.

Are services responsive to people's needs?

Inadequate

We rated responsive as inadequate because:

- Patients did not have privacy for phone calls as public phones were located in communal areas and not all had a hood.
- Patients frequently experienced cancellations to escorted leave and activities.
- Religious needs were not always met in a timely manner even though there were good spiritual care facilities on site.
- Special diets were not easy to access and there was little choice and variety.
- All patients were subjected to searches on return from off-site leave owing to smoking-related risks and a recent serious incident. However, this policy would not be appropriate for low secure or step-down services without individual risk assessment.
- Patients complained about the blanket restrictions in place on access to mobile devices, social media and communication technology.
- Patients did not have access to meaningful activity time due to staff being diverted to other tasks.
- Staff used the trust's pool cars to support patients to access activities and leave off-site. However, when the cars were diverted for other use, activities were cancelled.

Summary of findings

However, there was a wide range of facilities and activities available on and off-site (spiritual area, workshops, recreation centre, social club, sports hall, gym, and gardening) although access was limited when there were staffing shortages. There were ward-based activities and access to outside space for most wards.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- In September 2013, the CQC asked the trust to review the environment of the seclusion room shared by Whinfell and Bleasdale wards. At the time of the current inspection, the building works had finally commenced to address these concerns.
- There were delays in responding to maintenance and cleanliness issues on Calder, Greenside and The Hermitage wards.

However, there were examples of wards managed by committed managers with strong vision and values for their services. For example, the women's service operated a gender-based model of care, and Fellside ward strongly promoted hope and independence in patients. Management were accessible and supportive but this was not consistent across all services.

All wards received performance reports showing a range of data including compliance with mandatory training, sickness absence levels, and complaints. The trust had plans in place to address the issues we found, for example, improvements to some seclusion suites, and removing ligature risks.

The service was working in partnership with The University of Central Lancashire on research into the involvement of patients and families in violence prevention and management.

Summary of findings

Information about the service

The forensic inpatient/secure wards are part of the secure mental health service line delivered by Lancashire Care NHS Foundation Trust. All services are based at Guild Lodge which has a medium secure perimeter and consists of wards designated as low secure, medium secure or step down/rehabilitation. The forensic inpatient/secure wards service comprises the men's service (medium secure and low secure), the women's service (medium secure and step down/rehabilitation), and the acquired brain injury (ABI) service (low secure and medium secure).

Guild Lodge holds 14 wards which have been established in phases over a period of time. Phase one wards are the longest standing and include Calder, Greenside, Fairsnape and Fairoak wards.

We inspected all fourteen wards:

Fairsnape Ward, eight beds, male medium secure, admission and assessment

Calder Ward, 10 beds, male medium secure, high dependency

Greenside Ward, 12 beds, male medium secure, high dependency

Marshaw Ward, 10 beds, male medium secure, enduring mental illness

Fairoak Ward, 18 beds, male low secure

Dutton Ward, 15 beds, male low secure

Fellside East and West Wards, 25 beds (including five flats), male low secure and step- down/rehabilitation

Elmridge, nine beds, female medium secure, admission and assessment

Mallowdale, eight beds, female medium secure, continuing care and rehabilitation

Forest Beck, four beds (two double flats), female medium secure, step-down/rehabilitation

Bleasdale, nine beds, male medium secure, acquired brain injury

Whinfell, nine beds, male medium secure, acquired brain injury

Langden, 15 beds, male low secure, acquired brain injury

The Hermitage, eight beds, male low secure, acquired brain injury, step-down/rehabilitation.

The previous inspection of Guild Lodge took place on 10 to 12 September 2013 and involved the inspection of two wards, Whinfell and Bleasdale. At this inspection, some breaches of regulations were identified, which were met by the time of the re-inspection on 28 August 2014. The September 2013 inspection also noted concerns with the extra care and seclusion areas used by Bleasdale and Whinfell wards. It found there was no privacy screen or separation between the bed space and toilet facility. This meant people could be observed by staff using the toilet facility and the toilet was in a position very close to the head area of the bed. These issues were reviewed as part of the comprehensive inspection.

Our inspection team

Our inspection team was led by:

Chair: Peter Molyneux: Chair of South West London and St George's Mental Health NHS Trust.

Team Leader: Sharon Marston, Inspection Manager, Care Quality Commission (CQC).

Head of Inspection: Jenny Wilkes, Head of Inspection for Mental Health, Care Quality Commission (CQC).

The team that inspected forensic inpatient/secure wards was comprised of 13 people: two inspectors, one inspection manager, four mental health nurses, one occupational therapist, one social worker, one pharmacy inspector, one expert by experience, and two Mental Health Act reviewers.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed the information we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups. We also collected comments from boxes left on the wards we visited.

During the inspection visit, the inspection team:

- Visited all 14 wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 32 patients who were using the service and collected feedback from 50 comment cards from patients.
- Spoke with the managers or acting managers for each of the wards.
- Spoke with 45 other staff members including doctors, nurses, occupational therapists, social workers, and allied professionals.
- Interviewed 11 service managers/modern matrons with responsibility for managing services.
- Interviewed the divisional director with responsibility for these services.
- Attended and observed one hand-over meeting and three multi-disciplinary meetings.
- Attended a debrief meeting following a serious incident.
- Looked at 24 care records of patients.
- Carried out a specific check of the medication management on seven wards and reviewed 78 prescription charts.
- Visited the clinic rooms 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 provider's services say

We spoke with 32 patients at focus groups and during the inspection. Feedback about their experiences of Guild Lodge was mixed. There were positive comments about the staff. Concerns were raised about escorted leave and activities being cancelled, understaffing, unsafe patient mix on some wards, and the poor quality of food. Patients also complained about the smoking ban, blanket restrictions on mobile technology (IPADs, computers, mobile phones), and disrupted sleep owing to the practice of 15 minute night observations for all patients in medium secure wards.

At the end of the inspection we collected 50 comments cards from patients. There were some positive comments about the staff, and a lot of concerns about poor access to activities, cancelled or re-arranged leave, not enough staff, and the quality of food.

We reviewed patients' complaints during a 12 month period prior to the inspection. Patients had made complaints about a wide range of issues including concerns about safety on wards, availability and quality of food, cancellation of leave, and staff behaviour.

Summary of findings

Good practice

- The forensic inpatient/secure wards were recognised for patient engagement in service development and improvement, which was extensive. Patients had been involved in delivering control and restraint training to staff. Patients were involved in recruiting staff. Patients had been supported in starting up a car washing business on site. Patients were invited to support work on redesign of care pathways. In 2014, Guild Lodge won an award for patient involvement in designing a new ward and a picnic area. In 2013, Specialist Services won a National Service User Award (Service User Champion Guild Lodge: Risk Assessment).
- The forensic women's service operated a gender-based model of care which offered a holistic approach to care and recovery. Patients and staff collaborated to develop this in accordance with national guidelines on gender informed healthcare, mental health best practice and recovery initiatives. Patients were given a leaflet describing the model of care.
- Forensic inpatient/secure wards worked in partnership with The University of Central Lancashire on research into the involvement of patients and families in violence prevention and management.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that ligature risks are removed from Calder ward, Greenside ward, Fairsnape ward and The Hermitage.
- The trust must ensure that seclusion rooms on Calder, Greenside and Fairsnape wards afford patients privacy.
- The trust must ensure timely repair and maintenance of premises and replacement of equipment.
- The trust must ensure that patients have privacy when making telephone calls.
- The trust must ensure that patients' religious needs are met in a timely and responsive manner.
- The trust must ensure there is timely access to special diets, ensure choice and variety (for example, halal), and improve the range and quality of food.
- The trust must ensure that patients receive escorted leave and activities, in line with their care plans.
- The trust must ensure that staffing deployment across all wards meets the needs of patients (for example, reviewing the staffing establishments of the male medium secure wards and Dutton ward).

Action the provider SHOULD take to improve

- The trust should ensure that care staff have timely access to the electronic care records system.
- The trust should ensure that all pat downs of patients returning from leave offer patients privacy and dignity.
- The trust should ensure that all staff understand and correctly apply the Mental Capacity Act, and ensure consistency in record-keeping.
- The trust should consider reviewing the blanket policies on access to mobile technology, and night observations in terms of the frequency and method.

Lancashire Care NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bleasdale Calder Dutton Elmridge Fairoak Fairsnape Fellside Forest Beck Greenside Hermitage Langden Mallowdale Marshaw Whinfell	Guild Lodge

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.

We carried out two Mental Health Act (MHA) review visits during this inspection. We also checked understanding of the Mental Health Act and the Mental Health Act Code of Practice on the wards we visited.

Staff had a good understanding of the Mental Health Act in their daily work. Detention papers were present in the records we looked at and patients were informed of their rights under section 132 MHA, including their right of appeal. There were clearly visible notices around the ward with CQC information and ward activities. Approved mental

health professional reports from the time of admission were not available on all patients' records but some patients had been on the ward for many years. On all wards, rights were revisited at regular intervals.

Section 17 leave forms were on the files of all the records we scrutinised (we looked at both paper and electronic files). The dates of leave were clearly marked and different time periods for each type of leave stated. Risk assessments were attached to leave forms. Section 17 leave forms on the paper files were up to date and out of date section leave forms had been taken out of files. Section 17 leave was authorised through a standardised system, was appropriately recorded and included specific conditions. Patients were offered a copy of their leave forms.

All treatment was given under the appropriate legal authority. Certificates of consent to treatment (Form T2) and certificates of second opinion (Form T3) were in place to authorise treatment. Medication charts showed medication did not exceed second opinion approved doctor (SOAD) recommendations.

An independent mental health advocate (IMHA) visited Fellside ward on request and there was a poster on the ward visible to patients advertising the service. All patients we spoke to were aware of their right to see the IMHA and how the IMHA could support them in regard to their detention.

Mental Capacity Act and Deprivation of Liberty Safeguards

On Langden ward, patients had up to date capacity assessments after a recent change in the responsible clinician. On Fellside ward, there was inconsistency in the consultant's recording of the patient's most recent authorisation of their capacity to consent to treatment. In some patients' notes, an entry had been made to evidence this but in others we could not find such an entry.

On Fairoak ward, there was variable understanding of mental capacity in regard to consent to treatment, and records were inconsistent.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated safe as requires improvement because:

- The physical environment of Calder, Fairsnape, Greenside and Hermitage wards needed improvement.
- There was significant damage to the fabric of Calder and Greenside wards.
- There were ligature risks on Calder, Fairsnape, Greenside and Hermitage wards. However, there were plans in place to address all of the issues associated with the physical environment and ligature risks, and a programme of work was underway.
- Seclusion facilities on Calder, Fairsnape, Greenside wards were poorly equipped.
- Calder, Greenside and The Hermitage were in a poor condition and did not provide a safe environment.
- Greenside and Calder wards were not clean and hygienic.
- The trust had legitimately implemented a no smoking policy at Guild Lodge in January 2015 but this was not consistently applied across the site.

However, some wards were in good condition and presented safe, clean and pleasant environments. Security systems and processes for the site were good. Staff had a good understanding of safeguarding policies and practice. There were some plans in place to address some of the issues associated with the physical environment and ligature risks. Medicines management was in line with good practice with few exceptions.

Our findings

Safe and clean environment

Some of the ward environments in Guild Lodge were not safe, in particular, the phase one wards such as Calder, Greenside and Fairsnape, which accommodated the men's medium secure service. There were ligature points throughout these wards (toilets, bedrooms, bathrooms), and also present on The Hermitage ward. Calder ward had poor line of sight and observation at the site of two toilets at the end of the ward. Also on Calder ward, a panel was hanging off the wall, there were ripped settees, and three broken windows. Windows panes on some of the phase one wards were frequently broken. However, the trust assured us that the quality of glass was of the required specification for a medium secure environment.

The layout of Fairoak ward presented blind spots and poor line of sight in the communal areas. Some of these concerns were noted in the risk register.

There was significant damage on Greenside ward and it was in a poor state of repair. One room was out of use due to damage. Two windows had been broken and were boarded up. The ward environment was sparse and unwelcoming. The décor was tired and the furniture was worn. We were told new furniture was on order. The door window curtains were in poor condition and not fit for purpose. On Greenside ward, one patient's bedroom window lacked blinds, which meant he was denied privacy.

The patients on Greenside ward had shared access to two bathrooms, and two patients commented they did not feel these areas were safe. The toilets were in a poor state. There was poor observation of the outdoor space. Both public phones were broken. Staff were open and honest about the challenges presented by the environment.

Cleanliness was variable throughout Guild Lodge. Some wards such as Fairoak, Marshaw and Fellside were clean and tidy, and communal areas were clear and clutter free. Patients and staff praised the domestic staff. On Dutton ward, patients cleaned their own bathrooms under staff supervision. However, some patients expressed concerns that their bathrooms were not being cleaned because there was not enough staff to supervise and observe the activity.

There were marked differences between the phase one wards such as Calder, Fairsnape and Greenside, and the newer wards such as Fellside and Forest Beck in terms of fabric, layout, facilities, décor, and maintenance. Fairoak, a phase one ward, had been refurbished and felt warm and welcoming.

There were delays in responding to maintenance issues, damage and repairs, for example, on Greenside ward, both phones were broken, one of which had been out of order

Requires improvement

Are services safe?

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

for three months. The washing machine on Fairsnape ward had been out of order for three weeks; this had been reported on 11 April. In the meantime, a neighbouring ward did the patients' laundry. A patient commented that on occasion items had gone missing or been returned to the wrong person. On Calder ward, notice boards were not replaced weeks after being damaged.

Dutton ward had been split into two for safeguarding reasons. This meant that some patients had no access to the kitchen and drinks. This was rectified prior to our visit via the opening of a second kitchen, which had been locked in the past. Staff had carried out an environmental risk assessment and considered how they would manage the risks presented, and this was working well. Patients were pleased they had open access to a kitchen.

All wards had access to clinic rooms. Elmridge and Mallowdale wards shared one clinic room. On Fairoak and Forest Beck wards, there were no examination couches in the clinic rooms so patients could only be treated in sitting or standing positions. Patients were offered the option of being treated in their own rooms if they wished to lie down. Emergency resuscitation equipment was available on each ward as well as emergency drugs. There were robust systems in place to ensure these were checked daily.

Security was managed well. Access to Guild Lodge was through a central control centre, which also acted as the security control for access to most of the wards. Additional control centres were in place for wards that were unable to use the central control effectively because of their location. All staff had personal alarms and each ward had a designated safety and security lead on duty on each shift to oversee access, security and safety. Patients who had unescorted leave or informal status were supported by staff to leave and re-enter the premises in line with the security policy.

Access to the seclusion area on Greenside ward involved negotiating a narrow corridor, which presented risks of injury to staff and patients. There were other blind spots on Greenside ward but there were parabolic mirrors in place to mitigate for the risks. There was no pass hatch in the seclusion facility for food, drinks and medication. Staff said patients' food was often cold or delayed because a team was needed to enter and exit the seclusion room.

The trust's executive risk register indicated that extra care facilities on Greenside and Calder ward were not fit for purpose owing to the size of the area, and the lack of privacy and dignity for patients in receipt of care. Funding and agreement for two new seclusion areas had been approved, and remedial work had initially been planned for September 2014.

The seclusion facility on Fairsnape ward did not offer privacy to patients. The observation area was very small. Staff were provided with a chair when observing a patient in the seclusion facility. Elmridge and Mallowdale wards and Whinfell and Bleasdale wards shared seclusion rooms. The seclusion facility shared by Whinfell and Bleasdale wards was under renovation.

Staff supported their patients in seclusion facilities on other wards when their own facility was in use. For example, at the time of inspection, Calder ward staff were nursing a Calder ward patient in the seclusion suite on Fairsnape ward. This took staff away from their own wards while they were transferring and nursing the patient.

Environmental audits took place regularly on wards. Infection control audits had taken place in August 2014, and reports for Mallowdale, The Hermitage and Langden wards highlighted issues and gave recommendations.

The trust provided us with information on planned site improvements:

- Phase one anti-ligature works. There were some delays to this programme of work.
- Fairoak – completion by the end of 7 June 2015.
- Fairsnape – completion by end of 28 June 2015.
- Greenside – completion by end of 26 July 2015.
- Calder – completion by end of 23 August 2015.
- Phase one bathroom and bedrooms. This programme commenced in February 2015 and was due for completion in August 2015. At the time of inspection, this work was 45% completed. There were delays due to access, escort arrangements, materials, and design sign off.
- Greenside/Calder extensions. Plans were being developed with the clinical team for a new seclusion facility. A site visit to another hospital had been arranged for May 2015 to look at the design and layout of a newly-built seclusion suite and following this agree a final design. Work was planned to commence by July 2015 with completion set for December 2015.

Requires improvement

Are services safe?

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

- Curtains and door privacy. Installation of privacy blinds for phase one and two wards was re-scheduled for May 2015 owing to manufacturing delays.
- Seclusion hatches on Mallowdale and Elmridge wards were to be replaced as soon as possible.
- There were plans to assess doors that were failing to lock.
- Various improvements to Calder, Greenside and Fairsnape wards, which included re-painting, new flooring and repair or replacement of damaged windows.

Safe staffing

Patients raised concerns about staffing levels and patient mix. Some patients said Dutton, Calder, Greenside and Marshaw were unsafe. On these wards staff perceived the staffing establishments were unrealistic for meeting the needs of their patient cohorts. We explored these concerns further.

Guild Lodge had a response system for a cluster of wards, used in times of need or urgency. Staff, patients, and managers on the women's service and Fellside said staffing capacity was frequently depleted by staff being diverted to support other wards. This had an adverse impact on the patient to staff ratio, continuity of care and escorted leave and activities. The ward manager on Elmridge introduced twilight shifts to support patients with evening activities. However, these ceased because staff were diverted to support other wards.

Ward managers in the women's and acquired brain injury service described their staffing establishments as good. These services had undergone recent reviews of staffing requirements based on patient acuity, dependency, and needs. This resulted in increased investment. For example, trust records showed the women's service benefited from around £400,000 of additional investment in 2014. The ward manager described the staffing establishment on Fellside ward as reasonable. Fellside ward opened in 2011 and designed, and established to meet specific needs.

We reviewed the information on staffing establishment and vacancies for each ward at Guild Lodge for April 2015. The figures showed Guild Lodge was understaffed by 9% of its establishment but once newly recruited staff were in post, this would reduce to less than 1%. The trust had purposely over-recruited staff for some wards to take into account contingencies such as maternity leave and withdrawal following acceptance of a post. This approach had not changed the actual establishment for the wards, or filled the existing vacancies.

Guild Lodge used the most bank or agency staff to fill shifts across the trust. The high fill rate for unqualified staff exceeded the established staffing levels, which suggested this was the trust's response to managing the demand or mitigating for gaps in qualified staffing provision. Figures showed Guild Lodge relied mainly on bank staff to fill shifts although agency staff were also used mostly to fill gaps for unqualified staff. In January 2015, 1505 out of a total of 1647 shifts were filled by using bank or agency staff, and 142 shifts were not filled. In March 2015, for Guild Lodge as a whole, the average fill rate for qualified staff on day shifts ranged from 42% to 72%, and 57% to 185% for unqualified staff. On night shifts, the fill rate for qualified staff ranged from 75% to 117%, and 80% to 310% for unqualified staff. This suggested at any one time there were gaps in qualified staffing levels on day shifts on some wards in Guild Lodge. There were fewer gaps on night shifts. Dutton ward, in particular, had struggled to cover night shifts.

Staffing levels had been adversely affected by the opening of a new facility, The Harbour. A number of staff had applied to work there and this had left Guild Lodge with understaffing owing to vacancies. There were a number of relatively new or temporary managers on some of the wards. Bank and agency staff were being used to help manage shortages. On wards where managers perceived they had reasonably good staffing levels such as the women's service and Fellside ward, staff were frequently diverted to support other wards. This meant that wards were left with fewer staff, and consequently, patients' activities and leave were re-arranged or cancelled.

Each ward displayed the minimum expected staffing figures for registered nurses and health care assistants on each ward. Some wards, for example, Forest Beck, reported staffing levels were increased immediately to accommodate additional observation levels.

The new shift pattern of six hour shifts was unpopular for some staff and meant it was more difficult to meet patients' recreational activities and leave within the shift. Consequently, one ward returned to 12 hour shifts to better support staff and patients.

Requires improvement

Are services safe?

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

Between October 2014 and March 2015, sickness absence at Guild Lodge ranged from 6.9% to 9.5% with an average of 8.32%.The highest levels of sickness absence were attributed to Marshaw (18.2%), Langden (16.%), Bleasdale (11.5%) and Greenside (11.3%) wards. On Greenside ward, three regular staff were on long-term sick leave.

Patients expressed concerns about staffing levels, patient acuity and safety on specific wards such as Dutton, Marshaw and Calder. Dutton ward was described as a low secure ward with 15 beds for male patients providing a step- up and step-down service. The staffing establishment for Dutton ward was 26 whole time equivalent (WTE) posts, of which two posts were vacant. Three new staff had been recruited but were not yet in post. In March 2015, the fill rate for day shifts was 50% for qualified staff and 168% for unqualified staff. The fill rate for night shifts was 75% for qualified staff and 206% for unqualified staff. The ward struggled to fill the night shift quota for qualified staff, which was reflected in the lowest fill rate in Guild Lodge. Staff and patients on Dutton ward said the staffing levels did not reflect the acuity and patient mix on the ward. At the time of inspection, one patient was being nursed in the seclusion suite on 3:1 ratio which reduced the numbers of staff on the ward.

Marshaw ward was described as a medium secure ward with 10 beds for male patients. Many of the patents required high levels of observation. The staffing establishment for Marshaw ward was 21.4 WTE posts, of which one post was vacant. Three new staff were recruited but not yet in post. The fill rate for day shifts was 42% for qualified staff (lowest of all wards in Guild Lodge) and 130% for unqualified staff. The fill rate for night shifts was 97% for qualified staff and 309% for unqualified staff. The sickness absence level on Marshaw ward of 18.2% was the highest in Guild Lodge.

Marshaw ward meeting notes from February and March 2015 confirmed there were staffing issues on Marshaw ward owing to restrictions on agency staff, existing vacancies, short staffing for some weeks, sick leave, and no permanent ward manager or team leader in place. This was regarded as a risk given the patient acuity on the ward and that the ward was continuing to take new admissions. Staffing issues were affecting the effective functioning of the ward including patients' leave being cancelled, and low morale amongst staff and patients. My Shared Pathway was hardly being used, and supervision for staff was inconsistent.

A patient on Marshaw ward described three instances in three months of a staff member being left alone on the ward because other staff were diverted to deal with incidents elsewhere. A further three patients mentioned staff were left alone, and said staffing issues were having an impact on patients. One patient added that staff locked themselves in the office when they were alone, and two patients said they had witnessed staff in tears because of pressure. Patients on Marshaw ward were positive about the staff team and expressed sympathy for the staff. It was the patients' perception staff were not supported or appreciated by management.

Staff on Marshaw ward expressed concern about low levels of staffing and low morale amongst patients and staff. Staff said patients' activities and leave were frequently cancelled. Staff gave an example of a staff member being left alone on the ward for more than an hour when other staff had responded to incidents on other wards. Staff on Marshaw ward described a good staff team who supported one another but lacked support from management. A new (temporary) manager had just started in post after the previous manager had left.

Patients' needs were recognised but not always met owing to staffing issues or a lack of transport. The most recurring theme from patients (focus groups, comments cards, interviews) was in regard to home leave, community leave and activities being cancelled or re-arranged because there were not enough staff available to provide escorts. This also applied to supervised ward activities such as cleaning bathrooms on Dutton ward.

Calder ward was described as a medium secure ward with 10 beds for male patients. The staffing establishment for Calder ward was 25.4 WTE, of which a 0.5 WTE post was vacant. Three new staff was recruited but were not yet in post. The fill rate for day shifts was 72% for qualified staff and 288% for unqualified staff. The fill rate for night shifts was 100% for qualified staff and 298% for unqualified staff.

It was taking new staff several weeks to get access to the electronic care records system, which has recently replaced paper recording systems, for example, a staff member on Mallowdale wards had been waiting three weeks.

Requires improvement

Are services safe?

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All new, bank and agency staff were registered with the security control centre before they could have access to keys. The security control centre maintained a record of these staff.

We spoke to the trust about some of the issues related to staffing levels. They recognised Guild Lodge was experiencing understaffing difficulties, and shift patterns were an issue, which had affected recruitment. The trust's executive risk register stated that owing to unsuccessful recruitment and retention, some sickness absence and maternity leave, there was a shortage of registered nurses across the site. Additionally, owing to the number of newly qualified band 5 nurses, there were less experienced staff than the service has previously been accustomed to. The trust recognised this could compromise staff and patient safety. The trust also recognised the need to review staffing establishments on the men's medium secure wards and Dutton ward but this was not yet underway.

A major recruitment exercise was underway. In the interim, the trust had some actions in place to mitigate risks. These included service planning meetings twice a week with representatives from all wards, asking community teams for assistance, reviewing the policy around notice periods, and eliminating delays in the appointment process for new staff.

We found that Guild Lodge was clearly facing challenges in staffing wards adequately owing to a number of factors including vacancies, staffing establishments and staff deployment.

Assessing and managing risk to patients and staff

Since the implementation of the trust-wide no smoking policy on 5th January 2015, there had been an increase in covert smoking behaviour and smoking-related incidents, presenting a high risk of fire and injury to patients and staff. Reported incidents included using various items to obtain a light for cigarettes, for example, foil and electricity, shower gel, and toaster. Patients were also buying and selling matches, and asking patients on leave to bring in items. Secretive smoking was occurring throughout Guild Lodge, and we could smell cigarette smoke on Fairsnape ward. Staff responded to known smoking-related incidents with searches of rooms, removal of items such as shower gel, and advice to patients about risks. In addition, the service had introduced a blanket policy of searches for all patients on return from leave. However, this policy would not be appropriate for low secure or step-down services because patient would be expected to be afforded a greater degree of autonomy.

All patients returning from leave were subjected to routine pat down searches in the airlock at the entrance to Guild Lodge, which was fully visible. Staff of the same sex undertook the searches. Staff in the women's service said there was access to a quiet room for privacy, if required. Patients could refuse to be searched, and in such cases, risks were assessed on an individual basis.

In line with the trust's policy, the no smoking policy extended to community settings when staff were present, for example, escorted leave. However this policy would not be appropriate when patients were off the hospital site and would provide difficulty for staff to enforce when the policy only applied to trust sites. Staff and patients reported they were struggling to comply. Patients smoked irrespective of the no smoking policy. Staff supporting escorted leave were unsure how to respond when a patient smoked, or were afraid of the repercussions if they were to try to impose the policy off-site.

The trust was aware of the issues and risks since the no smoking policy was introduced. Guild Lodge had experienced an increase in violent incidents, a 100% increase in security-related incidents, and increased reporting of patient on staff aggression. Staff on all wards confirmed they were experiencing incidents related to smoking. Staff on Greenside ward confirmed illicit smoking had taken place in the shared toilets since the smoking ban was implemented.

Guild Lodge had experienced an increase in security incidents, which it acknowledged was partly due to the trust-wide smoking ban introduced on 5 January 2015. In December 2014, there were 32 security incidents reported at Guild Lodge. This increased to 88 security incidents in January 2015 but reduced to 31security incidents in February 2015. In March 2015, there were 44 security-related incidents, of which 19 were smoking-related.

Staff and patients in the women's service described an increase in self-harming behaviour since the introduction of the no smoking policy, as well as increased tension on

Requires improvement

Are services safe?

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wards and in relationships between patients and staff. Patients also described an increase in tension and frustration on the men's medium secure wards, where there would be fewer opportunities for leave.

Feedback from focus groups, comments cards and patient interviews indicated some patients did not feel safe on Dutton, Calder and Marshaw wards owing to the patient mix. This had been dealt with at times by moving patients to other wards, splitting the wards into two (Dutton), and using extra care and seclusion areas, where appropriate. Patients had expressed concern about the splitting of Dutton ward for safeguarding reasons, which meant some patients had no access to the kitchen and drinks. This was rectified prior to our visit via the opening of a second kitchen, which had been locked in the past.

Staff also raised concerns about safety on some wards owing to patient acuity and mix, in particular, men's medium secure wards. The trust recognised there were issues on some wards such as Calder, caused by a number of factors such as an increased number of prison transfers, the patient acuity and mix, the physical environment and staffing levels. An action plan had been developed to address the issues on Calder, and commissioners had been informed.

The action plan for Calder ward, dated March 2015, outlined a wide range of concerns. These included staff, clinical pressures, staffing model, culture, staffing levels, restrictive practice, staff attitudes, boundaries, communication, lack of support and leadership. Actions to be taken included deploying two senior nurses to support the ward, advertising vacancies, reviewing patients for their suitability to transfer to other secure services, and holding an away day for the staff team, which had been arranged for June 2015. Additional actions included rolling out a training package for all staff, blocking admissions and reducing the number of beds. At the time of the inspection, only a few actions had been implemented, for example, there was a major recruitment drive underway.

Enhanced safeguarding of adults and children training was mandatory for all mental health staff. In In May 2015, Guild Lodge's compliance with level one training for safeguarding vulnerable adults and children was in the region of 90%. However, compliance with level two (enhanced) safeguarding training ranged from 40% to 52%. Staff had a good understanding of the trust's safeguarding procedures and were confident in making referrals. Guild Lodge had made the most safeguarding referrals across the trust with 125 referrals made between January 2014 and February 2015. There was a dedicated safeguarding service within the trust to offer advice. Guild Lodge's Patient Safety Sub-Group meeting held in March 2015 was focused on safeguarding. It showed nursing staff had raised the majority of safeguarding alerts, with an action noted to check if medical staff were aware of the procedure.

Core mandatory training for staff included management of violence and aggression, Mental Capacity Act (incorporating Deprivation of Liberty Safeguards), and safeguarding adults and children. In January 2015, compliance with core mandatory training for secure services was 69.14%, which was the lowest in the trust. Compliance ranged from 69 to 84% across the trust, with an average of 75%.

Records showed good medicines management. Pharmacists visited the wards weekly. Medical staff were aware of NICE guidelines on prescribing medications. PRN (as needed) medication was reviewed every seven days.

Appropriate arrangements were in place for reporting and responding to medicines incidents and errors. Following a recent incident, prompt action was taken to review procedures for medicines receipt and administration at Guild Lodge wards to help ensure medicines' security was maintained at all times.

All wards had detailed and up to date team information boards which held information about safeguarding processes, compliance levels for mandatory training, complaints, and team priorities.

We reviewed the trust's strategy to minimise restrictive practices. The use of intentional prone restraint was no longer permitted within the trust, and alternative restraint training was being rolled out to all staff (both theory and practice). However in the six months prior to our inspection (October 2014 to March 2015), there were 171 incidents of restraint across the 14 wards in the forensic service. 20 of these restraints were in prone position. Some wards, such as Calder, had significantly higher levels of restraint. Restraint incidents were often related to a single patient, for example, of 14 restraints reported in October 2014, eight took place on Calder ward and all were related to the same patient

The trust was implementing positive behavioural approaches such as advanced statements. On Dutton ward,

staff had started discussions about using an advanced statement in the case of a patient with complex and challenging needs as part of the transfer plan to another ward. Staff and patients across the service were positive about the changes which had taken place particularly in regard to alternatives to restraint and seclusion.

There were a small number of posts dedicated wholly to safety and security. A violence reduction and security lead was based on site. There was a violence reduction lead nurse. A new post had been created for a safety and security supervisor.

Between 1 August 2014 and 11 February 2015, there were 17 incidences of seclusion in Guild Lodge, of which four involved long term segregation.

We looked at how relational security was managed within the service. Each ward had a designated safety and security lead for each shift. Their role was to manage relational security within the individual ward area, for example, signing patients, staff and visitors in and out of wards, and monitoring patients' and staff's movements in and out of wards. This role covered monitoring patients who had leave, managing the safety and security of the building, updating staff about risks and ensuring cutlery and other equipment was accounted for, and stored safely.

Staff supported patients who had unescorted leave or informal status to leave and re-enter the premises in line with the security policy.

Guild Lodge held monthly patient safety meetings which were widely attended (manager, risk manager, safety coordinator, modern matrons, clinical psychologists, clinical nurse specialist, safeguarding practitioner, ward managers, occupational therapists and service user and carer involvement representative). Business continuity was a standing item covering issues around staffing levels and how to respond to issues of staff shortages such as asking staff to cancel leave.

There was a family visiting area and facilities at the entrance of Guild Lodge, away from the ward environment, which meant children, could visit in an appropriate environment.

All patients were subjected to searches on return from off-site leave. These took place in the airlock area by staff of the same sex. The women's service said there was access to a quiet room if privacy was required. However this policy would not be appropriate for low secure or step down services because patient would be expected to be afforded a greater degree of autonomy.

Patients complained about disruption to their sleep on account of the frequency and method of observations at night. Patients described torches being shone into their rooms. On medium secure wards, all patients were subjected to 15 minute observations day and night, and on low secure wards, this practice was undertaken hourly, day and night. These were not carried out on the basis of the risks presented by individual circumstances although observation levels were increased if the risks required it.

Track record on safety

The trust had included a target reduction in violence of 30% as a strategic priority. Staff were aware of the actions Guild Lodge was taking to support this priority, which included reducing restrictive practices, close monitoring of all incidents and use of seclusion and holding post-incident debriefs.

Guild Lodge had developed a position statement on restrictive practices in line with the Department of Health (DoH) guidance on reducing the need for restrictive practices (2014). This showed a strong commitment to security and safety through a number of actions. These included thorough and robust processes for reporting and monitoring incidents. There were new posts focused on security and safety, and revision of existing job descriptions. Existing policies were being revised in line with national guidance and local requirements. There was a security working group in place. Random security compliance checks were taking place throughout Guild Lodge. A secure services induction for new staff was being implemented. There was a live electronic database, which stored key, use of the alarm system and safety and security training information for all clinical staff.

Staff had a good understanding of recent incidents which had taken place within their service.

The trust was implementing a safer wards programme for the men's medium secure service. This included a schedule to address ligature points.

The trust was implementing a programme of works to improve the physical environment of phase one wards.

Requires improvement

Are services safe?

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There was close monitoring of the use of seclusion facilities across the site by the management team. The seclusion policy indicated the response time for the responsible clinician, the requirement for a multi-disciplinary review, and stated who to inform. We observed an example of this in practice on Dutton ward.

Reporting incidents and learning from when things go wrong

For the six month period up to 31 March 2015, Guild Lodge reported 815 incidents to the trust's Datix system. A high proportion of these typically occurred in the dedicated acquired brain injury service, followed by men's medium secure services, in particular, Calder ward. For example, in October 2014, there were 97 incidents reported across the site, 56 were attributed to the acquired brain injury service, 33 were attributed to the men's medium secure service, 18 of which occurred on Calder ward. In March 2015, there were 179 incidents reported, of which 93 occurred in the acquired brain injury service, 52 in the men's medium secure service, 26 of which occurred on Calder ward.

Guild Lodge produced monthly safety assurance reports. Reports from October 2014 to March 2015 showed analyses of incidents highlighting trends and patterns covering the number, type and location of incidents, lessons learnt, number of staff debriefings by ward, and any changes to be implemented going forward.

Staff were aware of the processes for reporting incidents through the Datix system. Staff and management had a good understanding of serious incident reporting. There were good procedures in place for reporting, investigating incidents and subsequent debriefs. We reviewed a copy of an investigation report and attended a debrief meeting following a serious incident of violence involving restraint. The process was thorough and identified lessons learnt.

Ward level performance data on incidents and the safeguarding process were displayed on all team information boards.

Staff accessed debriefings following a serious incident and some staff said they valued this process especially after incidents of violence and aggression. Four staff said debriefings were not used regularly on Marshaw ward and they were afraid of being criticised. The safety assurance reports from October 2014 to March 2015 showed incidents had taken place on Marshaw ward but there was no mention of debriefings taking place.

The trust intended to ensure details about debriefings were entered onto Datix before an incident could be closed.

Are services effective?

Good

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

Summary of findings

We rated effective as good because:

- There were comprehensive assessments and care plans in place.
- There was a strong focus on physical health care needs and there was good access to a range of health services such as GP, specialist diabetic nurse, and podiatrist.
- Staff had a good understanding of their responsibilities under the Mental Health Act and patients were regularly informed of their rights.
- Guild Lodge was utilising recovery-based models of care such as my shared pathway and recovery star although implementation was inconsistent across the wards.
- There were good multi-disciplinary working practices in place on most wards.
- The women's service was operating a gender-informed model of care, which was regarded positively by staff and patients.

Our findings

Assessment of needs and planning of care

The service adopted my shared pathway and recovery star as assessment and care planning tools on all the wards in the service. However, implementation of these tools was inconsistent across the service. For example, they were fully embedded in the women's service and Fairoak ward, while on Marshaw ward staffing issues were delaying implementation.

There were good evidence-based care plans which covered people's medical, therapeutic, physical healthcare, and social needs, such as family visits and involvement. Care plans were updated and reviewed regularly on most wards. Patients were involved in developing their care plans but this was not always clear in care documentation. Patients were offered copies of their care plans.

The service employed a clinical nurse specialist for physical health to promote physical healthcare care across the service. Physical healthcare needs were assessed and met and there was good access to health services such as GP, optician, podiatrist, physical health nurses, ECG, and specialist diabetic nurse. Records of physical health care checks were comprehensive and up to date, and patients' blood pressure and weight was checked. At the time of inspection, physical health care documentation was in transition from paper to electronic copies. This meant records were not integrated and we saw this had been added to the risk register.

Male medium secure patients were admitted to Fairsnape ward for an assessment period of twelve weeks. The assessment process was comprehensive and multi-disciplinary. Full information was requested at referral stage, and this was followed by a psychiatric assessment prior to admission. Some patients stayed on the assessment ward for much longer than twelve weeks. One patient had been on the ward for seven months. This happened occasionally because of delays in transfer to other wards, or when a patient required a longer period of assessment owing to their individual needs.

Staff of all grades were invited to participate in the assessment and care planning process for patients with the exception of unqualified staff on Marshaw ward.

There was a dedicated ASD (autistic spectrum disorder) team. There was a gap around sensory needs assessments for patients with ASD and acquired brain injury. The trust had recognised this and intended to liaise with commissioners about it. Whinfell ward had secured funding for a part-time speech and language therapist.

Guild Lodge had implemented a new electronic records management system (ECR). ECR acted as a portal to two additional systems to make it fit for purpose. All patients' records were being entered or uploaded onto the system. Between 3 December 2014 and 23 January 2015, Guild Lodge reported 82 errors in the daily records on ECR as incidents. Access to, and navigation through the system was time-consuming. Staff required multiple logons. Locating essential records and the most recent documents was time-consuming. The issue was noted in the executive risk register and the action planned was to set up a task and finish group to explore solutions. Staff gave mixed views; some preferred the system but recognised it needed to be improved, while others preferred paper records, particularly in terms of easy and timely access to vital information.

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The service was using the historical clinical risk management (HCR) 20 v2 tool when version 3 was the standard guidance at the time.

For the six month period from July to December 2014, wards in Guild Lodge had the highest bed occupancy rates in the trust. Of 14 wards, 11 wards had occupancy rates of between 87% and 99%. Between January and April 2015, the highest bed occupancy rates in Guild Lodge were on Marshaw (87%), Calder (97%), Greenside (98%), Dutton (99%) and Fairoak (99%) wards.

Best practice in treatment and care

Patients had access to a number of psychological therapies based on individual needs assessment including cognitive behavioural therapy, dialectical behavioural therapy, solution-focused brief therapy, and anger management.

The women's service adopted a gender-based model of care which offered a holistic approach to care and recovery. This was developed with patients and staff, and informed by national guidelines on gender informed health care, mental health best practice and recovery initiatives.

Patients were given a leaflet describing the model of care.

The trust utilised recovery based models of care such as my shared pathway and recovery star although implementation was inconsistent across the wards. The acquired brain injury service had tailored the recovery model to their patient group.

The occupational therapy team was implementing a meaningful activity programme, and was developing plans for seven day services. The team was in the process of adopting model of human occupation screening tool, which is recommended for secure services by the College of Occupational Therapists.

There was a strong emphasis on physical health. There were a wide range of physical health services available to patients on site and in the local community. Patients were offered smoking cessation support and alternatives to smoking following the implementation of the no smoking policy across the site.

Our pharmacist inspector visited Fellside and Calder wards and checked medication records. Two patients had arrangements in place for self-medication, which were monitored closely.

The trust had a policy on self-medication which was operational but practice was not applied consistently in rehabilitation/step down wards. Patients were permitted to self-medicate on Fellside step down ward, however, patients on Forest Beck (step down ward) were not permitted to manage their own medication.

The trust's pharmacy team had recently completed a prescribing review at Guild Lodge. This highlighted several recommendations for investigation including a review of anti-psychotic polypharmacy, where depot and oral medication or a combination of a first and second generation antipsychotic medication were prescribed. This is important as prescribing more than one antipsychotic can increase the risk of side-effects.

The trust had reviewed pharmacy support to the Guild Centre to prioritise the provision of specialist pharmacist advice through attendance at the ward multidisciplinary team meetings. Proposals to increase pharmacy staffing were also under discussion.

Skilled staff to deliver care

Patients had access to support from a wide range of professionals through multi-disciplinary working, including medical, nursing, occupational therapy, social work, and psychology.

Trust performance data from January to March 2015 showed compliance with clinical supervision for all mental health inpatient services was 50%, below the full year average of 59%.

Staff had received modified training on control and restraint and alternative strategies in line with the trust's commitment to reducing restrictive practices. Instructors were placed on each ward to support staff with the change in practice.

Staff working in the acquired brain injury service were given an additional five days of focused training. The trust provided us with the details of the additional training for staff on epilepsy. This was theory based training to help staff understand the signs and symptoms associated with this condition.

The trust had introduced a new secure services induction, which was mandatory for all new staff.

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Some staff had access to regular clinical supervision and most staff were up to date with appraisals. On Fell Side ward, it was recognised that staff also received regular informal supervision, which the manager had started to record.

Pharmacists were based on site and attended multidisciplinary team meetings regularly. The trust employed dedicated leads for safety and security, physical health, and safeguarding. There was also a dedicated ASD team.

Multi-disciplinary and inter-agency team work

We observed three multi-disciplinary/care programme approach (CPA) team meetings on Fairsnape, Greenside and Fairoak wards, which were well structured, comprehensive and inclusive. There was multi-disciplinary attendance, feedback from all members, a detailed and thorough approach, and decisions and changes were reviewed at the end of the meeting.

On Langden ward, there was a good multi-disciplinary discussion between the consultant psychiatrist, team leader (nurse), occupational therapist and psychologist about supporting a patient to structure their memory processes to help reduce the patient's distress levels.

We observed a handover on one ward involving seven staff. A handover template was used; each patient's mental and physical health was discussed. Staff were made aware of issues and priorities, any warning signs/triggers noted in patients, new admissions, and general business matters.

Social workers based in the community forensic outreach services were aligned to wards to provide support for inpatients and to ensure some continuity when moving to community placements. One social worker commented on the good working partnerships between the inpatient and social work services.

Staff displayed a good understanding of the needs of the patients. Some unqualified staff in the women's service said they were included in multi-disciplinary team meetings and were encouraged to give their views. Unqualified staff on Marshaw ward said they were not invited to multi-disciplinary team meetings.

Guild Lodge employed a prison in-reach worker who liaised with five local prisons, prisoners, patients and families.

Some of the psychiatrists in Guild Lodge also worked in the prison hospital. This helped with communication between patients and agencies, transfer and transition plans, and continuity of care.

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

We carried out two Mental Health Act review inspections on Fellside and Langden wards. We also checked understanding of the Mental Health Act (MHA) and the MHA Code of Practice. We found that staff had a good understanding of the Mental Health Act and how it affected their daily work. Staff knew where to seek further advice if they had queries relating to the Mental Health Act. There was good communication between wards and the Mental Health Act administrators.

At the time of inspection, all patients in Guild Lodge were detained under The Mental Health Act 1983, with the exception of two patients. The informal patients were awaiting discharge. They had freedom of movement, and were aware of their rights, which were read to all detained patients frequently. Where patients struggled to retain the information, visual aids were used, for example on the Hermitage.

Staff had a good understanding of the Mental Health Act in their daily work. Detention papers were present in the records we looked at and there patients were routinely informed of their rights under section 132 MHA, including their right of appeal. There were clearly visible notices around the ward with CQC information and ward activities. Approved mental health professional reports from the time of admission were not available on all patients' records but some patients had been on the ward for many years.

Section 17 leave forms were on the files of all the records we scrutinised (we looked at both paper and electronic files). The dates of leave were clearly marked and different time periods for each type of leave were stated. Risk assessments were attached to leave forms. Section 17 leave forms on the paper files were up to date with out of date section leave forms taken out of files. Section 17 leave was authorised through a standardised system, was appropriately recorded and included specific conditions. Patients were offered a copy of their leave forms.

An independent mental health advocate (IMHA) visited Fellside ward on request and there was a poster on the ward advertising the service. All patients we spoke to were

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aware of their right to see the IMHA and how the IMHA could support them regarding their detention. The advocacy service was based on site. There was a female advocate available to the women's service. One patient said he could phone advocacy and they would respond the same day.

We reviewed in excess of 78 prescription charts. Certificates of consent to treatment (Form T2) and certificates of second opinion (Form T3) were in place in all cases in line with section 58 of the Mental Health Act 1983. We checked medication storage charts and found 3 out of 29 fridge temperatures had not been recorded in line with safe storage of medication procedures.

Staff received MHA Code of Practice training on an annual basis.

All treatment was given under the appropriate legal authority. Certificates of consent to treatment (Form T2) and certificates of second opinion (Form T3) were in place to authorise treatment. Medication charts showed medication had not exceeded second opinion approved doctor (SOAD) recommendations.

Good practice in applying the Mental Capacity Act

On Langden ward, patients had up to date mental capacity assessments after a recent change in the responsible clinician. On Fellside ward, there was inconsistency in the consultant's recording of the patient's most recent authorisation of their capacity to consent to treatment. In some patients' notes, an entry had been made to evidence this but in others we could not find such an entry.

On Fairoak ward, there was variable understanding of mental capacity in regard to consent to treatment, and records were inconsistent. A manager in the women's service recognised a knowledge gap around MCA, and made contact with the Mental Capacity Act (MCA) lead to improve the team's understanding of MCA. The ward round template was to be revised to include a section on capacity to help embed practice.

Concerns around capacity for specific issues were discussed at multidisciplinary team meetings. Two clinicians and two safeguarding leads were involved in a case where a difficult decision had to be made by a patient. In another case, a best interest meeting had taken place to review issues related to a relative's involvement in a patient's care.

Some staff, including some on Mallowdale and Elmridge wards, told us they had received training on the Mental Capacity Act, which included reference to the Deprivation of Liberty Safeguards.

MCA and consent training was mandatory for all mental health staff.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- Patients were treated with dignity, respect and kindness.
- The staff was dedicated and enthusiastic about patient care.
- Staff knew patients and their needs well.
- There was good interaction between patients and staff. There were lots of examples of patients' involvement in their own care and in wider service developments and improvements.

However, concerns were raised about escorted leave and activities being cancelled, understaffing, unsafe patient mix on some wards, and the poor quality of food. Patients also complained about the no smoking policy, blanket restrictions on mobile technology and disrupted sleep owing to the practice of 15 minute night observations for all patients in medium secure wards. Complaints during a 12 month period prior to the inspection showed patients had complained about issues including concerns about safety on wards, availability and quality of food, cancellation of leave, and staff behaviour.

Our findings

Kindness, dignity, respect and support

The majority of patients we spoke with gave positive feedback about the staff. One patient said staff on Marshaw ward were brilliant, caring and respectful and treated him like a human being. Patients on Elmridge ward said staff were caring. Patients in the women's service said they felt supported and staff understood them. One patient said there were good staff on Mallowdale ward who would see to patients' needs even if they were busy.

There was good engagement between staff and patients on Greenside ward and patients described staff as friendly, approachable and helpful. On Marshaw and Elmridge wards, staff knocked on patients' doors before entering, and patients confirmed this was common practice. Patients on Marshaw ward told us their possessions were kept safe in locked cupboards. Patients on Dutton ward had a lockable drawer in their own rooms, and access to a locker in the kitchen.

Staff displayed a very good understanding of the individual needs of patients.

In some cases, patients had concerns about staff behaviour, and complained about it, for example, patients on Whinfell, Dutton and Marshaw wards had reported staff were noisy at night.

An urgent search of all patients' rooms took place following a serious incident. This had upset some of the female patients as male staff searched their room. Staff explained the reasons for the search and there was a debriefing held afterwards. Patients said the searches were handled sensitively.

Information from patients we spoke with and from comment cards we received gave mixed views about patients' experience of dignity, respect and support. For example concerns were raised about escorted leave and activities being cancelled, understaffing, unsafe patient mix on some wards, and the poor quality of food. Patients also complained about the no smoking policy, blanket restrictions on mobile technology and disrupted sleep owing to the practice of 15 minute observations at night for all patients in medium secure wards. The review of patients' complaints during a 12 month period prior to the inspection showed patients had complained about issues including concerns about safety on wards, availability and quality of food, cancellation of leave, and staff behaviour.

The involvement of people in the care that they receive

There were patient representatives (champions) and regular patients' meetings (community meetings) on each ward. Advocates and the service user and carer lead attended on request. The champion on Fellside ward said he could raise an issue with the ward manager at any time. Patients on Elmridge ward had complained about poor access to leave after 7pm. In response to this, the ward manager introduced twilight shifts.

There were monthly champions' meetings, which were minuted. Actions were taken to follow up issues, for example, the group designed and implemented a template to record cancelled leave. Champions were invited to attend governance meetings.

Good

Are services caring?

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

All patients in the women's service said they were involved in the care they received. All patients were offered copies of their care plans. We observed three multi-disciplinary meetings at which patients were involved and consulted. A relative who was unable to attend the meeting was contacted in advance for their views. A patient on Whinfell ward was supported to chair his own CPA meeting.

On Fellside and Forest Beck wards, daily living skills such as budgeting, meal planning, cleaning and shopping were positively encouraged. On Fellside ward, patients were supported to self-medicate.

On Whinfell ward, staff held weekly meetings with patients to find out what activities they would like to do and then drew up a schedule. On Fellside ward, staff and patients managed all the catering.

There was strong patient and relative engagement in all aspects of life at Guild Lodge. Guild Lodge employed a service user and carer engagement officer who actively encouraged patient involvement in a range of projects. For example, patients were involved in designing the Guild Lodge service guide and some were involved in the recruitment of staff. Patients designed a tool to help police recognise mental health issues in custody and also been involved in control and restraint training. Patients set up a car washing business on site. Guild Lodge received awards for good practice in regard to patient involvement such as Design in Mental Health 2014, and National Service User Award 2013.

Guild Lodge developed collaborative risk assessment planning tools and training with patients and was involved in delivering training on risk assessments. Patients were involved in their own risk assessments.

There were several examples of patients doing voluntary or paid work in the community.

A Family and Friends Forum was held monthly.

Are services responsive to people's needs?

Inadequate

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

Summary of findings

We rated responsive as inadequate because:

- Patients did not have privacy for phone calls as public phones were located in communal areas and not all had a hood.
- Patients frequently experienced cancellations to escorted leave and activities.
- Religious needs were not always met in a timely manner even though there were good spiritual care facilities on site.
- Special diets were not easy to access and there was little choice and variety.
- All patients were subjected to searches on return from off-site leave owing to smoking-related risks and a recent serious incident. However, this policy would not be appropriate for low secure or step-down services without individual risk assessment.
- Patients complained about the blanket restrictions in place on access to mobile devices, social media and communication technology.
- Patients did not have access to meaningful activity time due to staff being diverted to other tasks.
- Staff used the trust's pool cars to support patients to access activities and leave off-site. However, when the cars were diverted for other use, activities were cancelled.

However, there was a wide range of facilities and activities available on and off-site (spiritual area, workshops, recreation centre, social club, sports hall, gym, and gardening) although access was limited when there were staffing shortages. There were ward-based activities and access to outside space for most wards.

Our findings

Access and discharge

There were clear admission and discharge pathways through the forensic services. Full information was required to be submitted with referrals. Individuals were assessed prior to admission to ensure their needs could be met in the service. Incoming patients were provided with information about the services at Guild Lodge. There were phased admissions to the women's service.

Male patients referred for medium secure care were admitted to Fairsnape ward for an assessment period of twelve weeks. Some patients stayed on the assessment ward much longer than twelve weeks. One patient had been on the ward for seven months. While some extended stays were based on individual needs and circumstances, there were also delays in transfers to other wards.

The service had strong links with the prisons in the local area and the number of prisoners being referred had increased by 30% in 2014. This presented challenges for Calder ward, which the trust was aware of. Meeting notes (March 2015) from Marshaw ward confirmed new admissions were going ahead even though there were concerns about regular staff being on sick leave, and changes to ward management.

Fellside ward which focused on rehabilitation/step down was successful in discharging around twelve patients each year. However, patients experienced some common barriers to discharge, which caused delay and frustration. These were caused by external factors such as the availability of appropriate accommodation, funding approval, and Ministry of Justice approval.

The facilities promote recovery, comfort, dignity and confidentiality

Patients expressed concern about the lack of privacy for telephone calls. All wards, with the exception of two wards, had public phones with hoods situated in open communal areas. The phone in The Hermitage did not have a hood. One ward had installed a booth around the telephone. On some wards, such as Greenside, patients also had access to cordless phones. Phones were not always in working order owing to damage or faults. Both phones on Greenside ward were out of order.

Patients complained about the blanket restrictions in place on access to mobile devices, social media and communication technology (IPADs, computers, mobile phones). Three patients described their need to make contact with family and friends. Patients on Fellside and Forest Beck step down wards were permitted to have non-SMART mobile phones. Patients did not have access to the internet on the wards including the patients on the step-down and rehabilitation wards. However, there was a computer suite within the Therapeutic Resource Centre, which was available to patients following an individual risk assessment.

Are services responsive to people's needs?

Inadequate

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

Guild Lodge was located in a rural area with limited public transport. As such, staff booked trust pool cars to access activities and leave off-site. The service normally had access to four cars but one had recently been written off by the insurance company. The cars were frequently in use with priority given to medical appointments.

Guild Lodge comprised of 14 wards which were built in phases over a period of time, with the exception of The Hermitage, which was a converted old house. This meant the facilities and conditions were variable throughout Guild Lodge. There were significant concerns about the facilities in phase one wards, which accommodated some of the men's medium secure service. In particular, we observed poor standards of environment on Greenside and Calder wards.

Calder, Greenside and Fairsnape wards had shared bathrooms. All other wards were in good condition and had ensuite rooms.

On Mallowdale and Elmridge wards, patients were permitted to have TVs in their own rooms. There were plans to re-decorate Forest Beck ward the following year. All wards had small outside areas.

On all wards, patients could personalise their rooms. Mallowdale and Elmridge wards had a small library.

There was no accessible drinks area on Greenside ward so patients had to ask staff for drinks.

Patients were offered the option of being seen in their rooms on Fairoak and Forest Beck wards, where the clinic rooms did not have examination couches.

Visitors could sign in at a separate desk at the central control centre, which was more welcoming. There was a separate area for children visiting the hospital located away from the wards.

Guild Lodge offered a wide range of on-site facilities. There was a workshop (Tarnbrook Unit) which offered vocational training such as wood work and metal work sessions during the week. There was a therapeutic resource centre run by occupation therapists which comprised a gym and a sports hall, and offered a wide range of activities from Monday to Friday. There was a social club (Gleadale Centre) which offered evening and weekend activities. There was a multi-faith room (The Sanctuary) which offered religious support. Guild Lodge had a grow your own project (allotment) which was outside the main site. Ward based occupational therapy assistants also provided support for patients off the ward and outside the hospital grounds. On Langden ward, two patients told us about trips to Preston to do personal shopping. There was a project with Lancashire police repairing and selling unclaimed stolen bicycles. There was a variety of activities available off-site in community settings, including paid and voluntary work, local library, gyms, shopping, restaurants and cafes.

A variety of activities were offered on wards. For example, on Mallowdale ward, the activities included a walking group, cooking, outings, bingo, crafts, and card-making. On Mallowdale and Whinfell wards, activities were chosen by patients and then scheduled.

Meeting the needs of all people who use the service

We reviewed a sample of activity plans on Dutton ward which showed patients received below 25 hours per week of meaningful activity. On Forest Beck ward, patients received the full 25 hours of meaningful activity. However, there were occasions where leaving the site boundary to smoke was regarded as an activity. On Hermitage ward, during March 2015, patients were offered between 13 and 21 hours of meaningful activity per week. There was reference to the delay in facilitating the 25 hour activity programme in a care record on Greenside ward.

The notes of the service user group meetings showed cancelled activities and leave were common complaints. A relative had also complained about a patient's leave for a family event being cancelled and the relative had not been informed.

The occupational therapy team said the main reason for activities being cancelled was transport being diverted at the last minute for use at appointments.

A ward manager and staff said it was very distressing to patients whenever leave and activities were cancelled, and wherever possible, they would try to re-arrange them. In the women's service, the occupational therapist helped to cover leave and activities when there were staff shortages. Two patients on Marshaw ward said leave and activities were cancelled but attempts were made to re-arrange them. Review of meeting notes on Marshaw ward confirmed that leave was cancelled owing to staffing issues. Staff on Marshaw ward said they did not have time to facilitate activities, and activities were inconsistent and

Are services responsive to people's needs?

Inadequate

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

not structured. On Fellside, Elmridge and Mallowdale wards, activities and leave were frequently cancelled because staff were diverted to other wards in response to incidents or understaffing.

Activities were rarely cancelled for patients with unescorted leave, for example, on Forest Beck, Fellside and Fairoak wards.

The occupational therapist service aimed to assess all new admissions within 48 hours. The occupational therapy service was keen to increase vocational activities for women.

Patients expressed dissatisfaction with the trust wide no smoking policy.

There were good religious facilities on site and religious leaders could be invited to Guild Lodge upon request. For example, an Imam often visited a Muslim patient. However, access to religious facilities was inconsistent. Two patients said they found it difficult to access religious services. In one case, the lack of response to a patient's request led to a serious incident.

Patients and staff on some wards including Dutton, Whinfell, Greenside, Mallowdale and Elmridge wards raised concerns about the food describing it as poor quality, tasteless, lacking in choice and not fresh. One patient on Marshaw ward kept his own food supply for bad days. There was dissatisfaction with the two day advance ordering process, especially for patients with acquired brain injury. While catering for special diets was provided, for example, vegetarian, halal, altered consistency, it was described as 'hard to get' and 'same'. An example was given of a service user receiving the same halal microwave meal every day. There were no complaints about the food on Fellside ward, which managed its own budget and catering at ward level.

A patients' shop was open twice daily. There was a vending machine on site but it was outside the secure perimeter.

On some wards, such as in the acquired brain injury service, information about ward activities was advertised in easy to read and pictorial formats.

Gender was taken into account in terms of assessing risk and activities and leave. The women's service recognised the need to increase women's engagement in the Champions' Forum and the In and Out Forum, and Occupational Therapy were considering offering more women-friendly activities.

Listening to and learning from concerns and complaints

There were patient representatives (champions) and regular patients' meetings (community meetings) on each ward. Advocates and the service user and carer lead attended on request. The champion on Fellside ward said he could raise an issue with the ward manager at any time. On Fairoak ward, there was a 'you said, we did' section on the noticeboard.

The service user and carer lead was described as active and supportive in developing patients and relatives groups, and helping patients and relatives raise and address issues. Patients and relatives were encouraged to apply a solution-focused approach to issues, for example, a common complaint was about escorted leave being cancelled. The group designed a form for recording each individual instance of leave being cancelled. This was in the process of being rolled out to all wards. Guild Lodge ran a Family and Friends Forum.

Staff were aware of the complaints procedure and how to manage complaints which were made directly to them. Patients were aware of the complaints procedure but some said they had no confidence in it. One patient described how he struggled to get access to a modern matron to complain about staffing levels on Marshaw ward.

We reviewed a list of complaints made by patients in Guild Lodge. In the twelve month period prior to the inspection, Guild Lodge wards received 65 complaints, which was the highest number of complaints throughout the trust. Dutton ward received 15 complaints, of which 7 were upheld. Langden ward received 11 complaints of which 9 were upheld. Patients made complaints about a wide range of issues including concerns about safety on wards, availability and quality of food, cancellation of leave, and staff behaviour. Complaints were fully considered. Outcomes included written apologies to patients, improving patients' understanding of policies and practices, adding issues and outcomes to Guild Lodge's share the learning document, improving information, guidance and publicity, and supervision of staff.

Are services well-led?

Requires improvement

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

Summary of findings

We rated well-led as requires improvement because:

- In September 2013, the CQC asked the trust to review the environment of the seclusion room shared by Whinfell and Bleasdale wards. At the time of the current inspection, the building works had finally commenced to address these concerns.
- There were delays in responding to maintenance and cleanliness issues on Calder, Greenside and The Hermitage wards.

However, there were examples of wards managed by committed managers with strong vision and values for their services. For example, the women's service operated a gender-based model of care, and Fellside ward strongly promoted hope and independence in patients. Management were accessible and supportive but this was not consistent across all services.

All wards received performance reports showing a range of data including compliance with mandatory training, sickness absence levels, and complaints. The trust had plans in place to address the issues we found, for example, improvements to some seclusion suites, and removing ligature risks.

The service was working in partnership with The University of Central Lancashire on research into the involvement of patients and families in violence prevention and management.

Our findings

Vision and values

Staff were aware of the values underpinning their service areas.

The women's service operated a gender-informed model of care which most staff and patients felt positive about.

Some staff were passionate about their jobs, for example, the women's service. Staff said they felt protective towards the patients. One staff member said it was rewarding to work with the female patients. Staff on Marshaw ward were frustrated by staffing pressures and crises, which meant that that they could not do their jobs effectively.

The rehabilitation service on Fellside ward adopted values focused on hope and independence. This was evident from patient and staff feedback, individualised risk assessments, community access, and self-medication.

Good governance

There was a dedicated management group for forensic inpatient/secure wards. Modern matrons supervised the ward managers and met frequently with ward managers and among themselves to ensure performance was monitored.

All ward managers received information about their ward's performance. This included mandatory training compliance, absence levels, current vacancies, and utilisation of bank and agency staff. Some of this information was displayed on each ward's team information boards.

In the women's service, team leaders undertook clinical audits on a monthly basis.

There were robust processes in place for cascading new NICE guidance on medication.

There were good systems in place for collating and analysing information on incidents, use of restraints and seclusion facilities, on a ward by ward basis.

In September 2013, the CQC asked the trust to review the environment of the seclusion room shared by Whinfell and Bleasdale wards. The building works had finally commenced to address these concerns at the time of our inspection. At this inspection, we noted delays in responding to maintenance and cleanliness on the Calder, Greenside and The Hermitage wards.

The trust recognised there was a gap in service for low secure services for women and were considering options to address this.

During the inspection we met with the director, assistant director, service manager and safeguarding lead to discuss quality improvements to the service. This included the plans to improve the safety and facilities offered in phase one of Guild Lodge.

We discussed the concerns about Calder ward with senior manager for Guild Lodge. The response from the managers that patients needed to understand the differences between being accommodated in prison and receiving care and treatment in a medium secure hospital ward, where

Are services well-led?

Requires improvement

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

there may be less flexibility and access to smoking, mobile telephones and activities. However patients were finding secure services more restrictive than prison which was had a detrimental impact upon their mental health needs.

The trust was reviewing some aspects of men's medium secure service. For example, an assessment tool was being piloted which aimed to determine the level of acuity of patients and track them through services at Guild Lodge. The referral process was redesigned and as a result the admission process to Guild Lodge had improved.

Leadership, morale and staff engagement

Staff were aware of the senior management team and modern matrons for their service lines. Staff from the women's service and the acquired brain injury service experienced daily or frequent contact with their modern matron. However, staff and patients on Marshaw ward said the modern matron was not visible on the ward.

There was significant variation in staff reports about management style and leadership. Staff from the women's service and acquired brain injury services and Fairoak ward spoke positively about the support from their ward managers and modern matrons. Feedback from Dutton ward was mixed citing staffing levels and patient acuity as concerns. On Calder, Marshaw and Greenside, poor leadership and management support were mentioned.

Staff in the women's service and Fairoak ward received regular supervision, perceived an open culture and said staff participation was encouraged. Group supervision notes from four wards showed reflective practice was in place, including in-depth analyses of patients and issues, and learning from incidents.

The ward manager on Forest Beck was given the opportunity to access leadership training. Staff from Mallowdale, Elmridge, and Forest Beck wards said training was available and encouraged. The perception of staff on Marshaw ward was of few training opportunities being available to them.

In all cases, staff said they supported one other. On Mallowdale ward, staff said there was great team solidarity and support. One doctor said there was a good supervision network for doctors. On Elmridge ward, staff said there was a good staff team. Staff were enthusiastic and motivated on Fairsnape ward.

Comments from staff interviews and focus groups suggested staff morale was variable throughout Guild Lodge. It was staff's perception that a combination of factors was affecting patients' mental health. Staff gave examples of key issues which included frequent changes in ward management such as on Marshaw ward. New shift patterns were unpopular with some staff. Wards were experiencing understaffing. The service had a large number of vacancies owing to a high staff turnover. Management recognised staff were under pressure and started to take action to address some of the issues. For example, there was a major recruitment drive underway.

There were inconsistencies throughout Guild Lodge in terms of the physical ward environment, staffing levels, perception of management style, and patient acuity.

Commitment to quality improvement and innovation

The trust had implemented a reducing violence and aggression programme which involved a ban on intentional prone restraint, as a last resort, and training in alternative strategies. This had been supported by a revised training programme and access to instructors on wards to help embed new strategies. Staff commented favourably about the change of approach. There was evidence of a reduction in the use of prone restraint and seclusion facilities. The trust safety assurance tool recorded a decrease in the use of prone restraint from October 2014 to March 2015. However, since the no smoking policy was introduced in January 2015, the number of incidents of restraint had been variable. The figures were as follows:

- October 2014 decrease in use of restraint from 20 (September 2014) to 14 incidents. Four incidents of prone restraint recorded.
- November 2014 increase in use of restraint from 14 to 23 (64% increase). Five incidents of prone restraint recorded.
- December 2014 increase in use of restraint from 23 to 25. Three incidents of prone restraint recorded.
- January 2015 increase in use of restraint from 25 to 34. Three incidents of prone restraint recorded.
- February 2015 decrease in use of restraint from 34 to 23 (32% decrease). Zero incidents of prone restraint recorded.
- March 2015 increase in use of restraint from 23 to 52 (126% increase). Zero incidents of prone restraint recorded.

Are services well-led?

Requires improvement

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

The implementation of electronic care records was ongoing. There were a number of teething problems that needed to be addressed.

The service was working in partnership with The University of Central Lancashire on research into the involvement of patients and families in violence prevention and management.

Large touch screens were being installed in all staff observation rooms and were already in use on Marshaw and Fairoak wards. These showed patient leave information and displayed the site environment.

The service had adopted recovery star and my shared pathway. Implementation was variable on the wards. It was embedded well in the women's service and on Fairoak ward. Staff and patients' feedback, and review of meeting notes showed poor implementation on Marshaw ward. The trust's audit of compliance and implementation of my shared pathway showed compliance ranged from 63% to 65% for the men's medium secure, women's and the acquired brain injury services. The men's low secure service had achieved 90% compliance.

The service had developed a safer wards programme which aimed to address safety concerns on the phase one wards. The plans showed a wide range of improvements were planned. Some work had already commenced and improvements could be seen on Fairoak ward. However, there were also some delays.

The service employed a dedicated service user and carer lead who supported patient engagement and achievements. Patients had been involved in delivering control and restraint training to staff. Patients were involved in recruiting staff. Patients had been supported in starting up a car washing business on site. Patients were invited to support work on redesign of care pathways. In 2014, the service won an award for patient involvement in designing a new ward and a picnic area. In 2013, Specialist Services won a National Service User Award (Service User Champion Guild Lodge: Risk Assessment).

Guild Lodge reviewed the care pathway for acquired brain injury services and found it was effective. Guild Lodge intended to work with commissioners to develop a service specification tailored to the acquired brain injury service.

The trust had developed a Quality SEEL (Safety, Effective, Experience, Leadership) programme comprising self-assessment, in-year monitoring and review. An internal audit report, dated October 2014, found limited assurance of compliance in regard to governance, reporting, and recording.

The trust's quality priorities included safer staffing, physical health care, violence and aggression, Quality SEEL, and quality improvement plans. These were at various stages of development and implementation throughout the trust.

The trust had undertaken a clinical audit in November 2014 relating to use of the Mental Capacity Act. This was in response to concerns raised by the CCQ in 2013.

The service showed a commitment to self-evaluation and continuous improvement. In January 2014, Guild Lodge successfully completed the self and peer review parts of the Quality Network for Forensic Mental Health Services annual review cycle. The peer review identified areas for improvement which included staff's perception of a lack of management presence on the wards. It also noted there was sometimes a lack of activity during the evenings and weekends owing to staffing numbers. Guild Lodge also participated in the Quality Network for Forensic Mental Health Services review in February 2015.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found that not all premises and equipment used by the service provider were suitable for the purpose for which they were being used. This was in breach of Regulation 12(1)(d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **How the regulation was not being met.** • The physical environment of Calder, Greenside and The Hermitage wards was in poor condition, including significant damage, and did not provide a safe environment. • Greenside and Calder wards were not clean and hygienic. • There were ligature risks on Calder, Greenside, Fairsnape and The Hermitage wards. • Seclusion facilities on Calder, Greenside and Fairsnape wards were poorly equipped.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met.** • All wards, with the exception of two wards, had public phones with hoods situated in open communal areas. • The phone in The Hermitage did not have a hood. • Phones were not always in working order owing to damage or faults. Both phones on Greenside ward were out of order. **This was in breach of Regulation 10(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met.** • Patients frequently experienced cancellations to escorted leave and activities. **This was in breach of Regulation 18(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met.** • In September 2013 the CQC asked the trust to review the environment of the seclusion room shared by Whinfell and Bleasdale wards. At the time of the current inspection the building works had finally commenced. • We noted delays in responding to maintenance and cleanliness on the Calder, Greenside and The Hermitage wards. **This was in breach of Regulation 17(2)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**