Bradley Woodlands Low Secure Hospital

Quality Report

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

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

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

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

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

Overall summary

We rated Bradley Woodlands Low-secure Hospital as **requires improvement** because:

- Staff lacked a basic understanding of the Mental Capacity Act 2005 and their individual responsibilities in relation to it. They could not provide examples of its use in their work and were seen making decisions without assessing the capacity of the patient.
- Staff did not treat patients with kindness and respect when they expressed their wishes and feelings.
- Patients' access to activities was limited and planned activities were too often cancelled. From April to July 2015, 186 out of 637 planned activities did not go ahead. Of these, the hospital cancelled 68 activities because of low staffing levels. The physical spaces for planned activities were not always available.
- The service wanted to deliver patient-centred care; they had introduced a care pathway approach to increase patient involvement. However, we still saw interventions and choices being made by staff rather than patients.

Summary of findings

- The layout of the wards created challenges for staff to work as a team. Support workers in the apartments felt isolated from the rest of the hospital. They did not have access to the internet, and most paper information was stored in the nursing office. Nurses and support workers found meetings difficult to attend when on shift.
- A low-secure hospital requires a seclusion facility. At the time of our inspection, this had not been available since June 2015. Plans were in place for it to be refurbished and re-opened by September 2015.
- The provider target for staff completing their mandatory training was 90%; however, only 73% of staff had completed this at the time of the inspection.

However,

- The hospital assessed each patient before they were admitted to make sure the hospital was the right environment for them and that it was able to meet their needs.
- The hospital had a wide range of facilities and amenities for treatment and rehabilitation. If patients had greater access to these, their care would be improved.
- Managers were visible on the wards and talked with patients on a daily basis.
- The new management team expected high standards and consistency from itself and its staff, and had put systems in place to ensure this.
- Managers and staff saw safeguarding as the responsibility of all those working in the hospital. Staff were well-trained in safeguarding and knew how to report concerns to external agencies.
- All staff had quarterly meetings with their supervisors and new staff had these monthly during their probationary period. The service was working towards increasing the one-to-one support for clinical staff through monthly supervision.
- There were good systems in place to ensure staff complied with the Mental Health Act 1983.

Summary of findings

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This report describes our judgement of the quality of care provided within this core service by Lighthouse Healthcare. Where relevant we provide detail of each location or area of service visited.

We base our judgement 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.

We have reported on one core service provided at Bradley Woodlands Low-secure Hospital bringing together the two wards to inform our overall judgement of Lighthouse Healthcare.

Summary of this inspection

Background to Bradley Woodlands Low Secure Hospital

Bradley Woodlands is a purpose-built low-secure hospital located on the outskirts of Bradley near Grimsby. Healthlinc Individual Care Limited runs the hospital. It is registered to take up to 23 people who have been detained under the Mental Health Act 1983. Bradley Woodlands hospital provides low-secure treatment for men and women with learning disabilities, complex conditions or mental health problems.

There are two wards Willow for female patients and Maple for male. Both wards have separate apartments that can accommodate a maximum of four patients. At the time of our inspection Maple ward had nine patients in three apartments, Willow ward had eleven patients in six apartments. Each patient has their own bedroom and each apartment has its own kitchen and living area. The wards are not physically separate units.

The registered manager of Bradley Woodlands independent hospital is also their controlled drugs accountable officer and the registered manager of Bradley Apartments, a specialist learning disability residential care home service next door. This is not a step down service for patients from the hospital.

An unannounced responsive inspection took place on 19 March 2014. This found that the hospital was not completing the appropriate consent to treatment assessments required under the Mental Health Act 1983. The hospital had prescribed medication without this authority. Immediate action was taken to resolve this. Under the Health and Social Care Act 2008, we expect people to give consent to their care and treatment, and understand and know how to change decisions about things that were previously agreed. On our inspection, the use of the Mental Health Act was good. All detention documentation complied with the Mental Health Act code of practice.

A Mental Health Act monitoring visit took place on 13 March 2015. This considered Domain 2: detention in hospital. This raised issues relating to the need for physical health examinations and patients' involvement in care planning. The provider submitted an action statement on 1 May 2015. We reviewed these action plans on our inspection and found them to be completed.

This is the first inspection of Bradley Woodlands independent hospital using the CQC's new methodology.

Our inspection team

Our inspection team was led by Christine Barker, Care Quality Commission inspector

The team included CQC inspectors and a variety of specialists:

- an expert by experience
- one CQC inspector
- a mental health nurse
- a Mental Health Act reviewer
- a consultant psychiatrist.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about this service and asked other organisations for information.

During the inspection visit, the inspection team:

- visited both wards at the hospital site to look at the quality of the ward environment and to observe how staff cared for patients
- spoke with 11 patients who were using the service
- spoke with four carers of patients using the service
- spoke with 26 staff members including an activities co-ordinator, two administrators, a deputy manager, a doctor, a hospital manager, a lead nurse, six nurses, a service director, a service trainer, seven support workers and a quality manager
- spoke to an external social worker and practice nurse visiting the service
- attended and observed one hand-over meeting, one care programme approach (CPA) meeting and a multidisciplinary meeting for three service users
- attended and observed one hospital planning meeting, one morning meeting, one patient involvement forum and one meeting of the smoking cessation group
- reviewed the Mental Health Act paperwork for 11 patients
- carried out a specific check of the medication management on both wards including prescription charts and physical health checks
- looked at a range of policies, procedures and other documents relating to the running of the service
- reviewed 21 patient records
- reviewed five staff records of supervision, appraisal and training.

Information about Bradley Woodlands Low Secure Hospital

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Summary of this inspection

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What people who use the service say

We spoke with 11 patients and four of their relatives.

Patients told us they had been involved in planning their care and supported by staff to do this. Four patients were able to show us their care plan and one patient talked about chairing his own review. Two relatives were pleased about significant successful reductions in previously high levels of medication for patients since admission to this hospital.

Patients liked being able to personalise their rooms. Relatives wanted to see patients' rooms. One relative reported that staff had told them that they might allow this soon.

Some patients spoke of being respected by staff; however, others spoke of being shouted at and misunderstood by staff. Patients saw the managers most days and were aware they could complain to them or the advocate. Relatives told us that they found staff to be caring and supportive; however, there were some concerns about the limited information support staff seemed to have about the background of the patients in their care.

Patients talked of having little choice of activities. They were frustrated at the number of changes and cancellations made to planned activities. Relatives expressed concerns about cancelled activities, especially at weekends.

While some patients had become involved in smoking cessation, we heard significant concerns about the impact on them of the proposed smoking ban.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- individuals could be trapped inside an apartment if the door was shut and blocked by someone behind it
- under the Mental Health Act 1983 Code of Practice, programmes may impose restrictions to manage risk; however, access to a comfortable environment should never be restricted or used as a 'reward', as was the case for a patient we saw
- staff cancelled a high amount of home (section 17) leave, which limited patients access to the community or their families
- the hospital had not set a timeframe to replace a number of identified ligature points in the apartments with anti-ligature fittings
- at the time of our inspection there was no seclusion room available, though this was due to re-open after refurbishment in September 2015
- the hand washbasin tap in the clinic room did not meet with current guidelines as it had separate hot and cold water taps preventing water reaching the correct temperature for hand washing
- some support staff felt vulnerable when alone with patients in apartments
- only 73% of staff had completed mandatory training, against a provider target of 90%.

However,

- there were separate male and female sleeping areas, and every patient had their own bedroom with an en suite bathroom
- the ward was clean and had a range of indoor and outdoor spaces
- staffing levels were consistent and the hospital was able to respond to the changing needs of the patient group
- staff reported incidents and there was evidence of managers sharing lessons learned among staff teams
- staff and managers saw safeguarding as everyone's responsibility: training was in place and concerns were appropriately reported to external agencies
- staff supervision was in line with the provider's quarterly target and new staff had monthly supervision during their probationary period.

Summary of this inspection

Are services effective?

Requires improvement

We rated effective safe as requires improvement because:

- staff did not show a good basic understanding of the Mental Capacity Act 2005
- staff were unclear about their individual responsibilities under the Mental Capacity Act 2005
- staff did not always use an appropriate method to communicate to a person lacking understanding their rights as a detained patient
- staff did not consistently base routines on patients preferences
- patients had difficulties in accessing appropriate activities.

However,

- there were good systems in place to ensure staff complied with the Mental Health Act
- staff completed physical and mental health assessments on admission
- staff involved patients in planning and reviewing their care
- one-to-one supervision met the provider's target and the differing needs of new staff.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- staff did not consistently deliver patient-centred care
- staff were not always kind and respectful to patients when they expressed their wishes and feelings
- patients' access to activities was limited and planned activities were too often cancelled

However,

- staff involved patients in planning their care
- patients were able to personalise their space
- relatives were involved in reviewing care.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- access to activities chosen by patients was limited
- it was not clear to patients how to raise a complaint outside the hospital
- while there was some support for patients to aid their communication, we did not see support tools in use specifically to meet individual needs
- not all staff had knowledge and understanding of patients' individual life histories

Summary of this inspection

- some apartments appeared shabby and in need of redecoration.

However,
- staff planned assessments and discharges well
- there was open communication between the patients and senior managers
- there was a wide range of facilities and amenities within the hospital.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- at times interventions and choices were made by staff rather than patients
- there were issues for support workers around access to information
- it was hard for support workers to attend meetings to aid communication when on shift because of low staff numbers
- the physical structure of the ward created challenges for team working, which affected morale.

However,
- there was evidence of an improving culture under the new management regime
- supervision for all staff took place within a monitored structure
- there was positive direct communication between management and patients.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings to determine an overall judgement about the provider.

A Mental Health Act reviewer visited the hospital as part of this inspection. They reviewed the detention documentation for the detained patients.

The use of the Mental Health Act was good, with detention documentation complying with the Mental Health Act code of practice. The provider had a Mental Health Act administrator who completed audits and scrutinised documentation. Staff felt supported by this and we saw an efficient and effective range of systems to support nursing and medical staff in meeting the responsibilities of the Act.

Completed consent to treatment forms were located with prescription charts. Staff informed patients of their rights verbally and through written and pictorial formats.

The provider had access to an independent mental health advocacy service. All patients were able to access this. We saw attendance by the advocacy service at relevant meetings.

Patients who were able to understand their rights confirmed that staff regularly discussed these with them. Staff used pictorial and easy-read formats to assist in communicating the information and could seek the assistance of the advocacy service in order to ensure that patients understood their rights. However, staff told us some patients would never understand their rights but had this information read to them weekly anyway.

The members of staff concerned with tribunals and hospital managers' appeals believed patients with a certain amount of savings had to fund a solicitor for tribunal hearings. This was incorrect as all patients are entitled to a solicitor for tribunals free of charge. Public funding for a solicitor is limited to appeals to tribunals and not hospital managers' hearings.

Ministry of Justice (MOJ) authorisation for leave was required for four patients. The provider had processes in place to ensure that section 17 leave forms were drawn up in accordance with MOJ authorisations. Section 17 leave forms were available, clear and struck out or ended after review. Staff completed risk assessments prior to patients taking section 17 leave. However, the nurse responsible for the pre-leave risk assessment of the patient had no access to the authorisation from the Ministry of Justice at this point. They were therefore unable to confirm that the registered clinician's authorisation was valid and correct. Staff reviewed leave in records when a patient returned.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received mandatory training in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff told us this training was limited to an overview of the principles. Four qualified nurses told us they required more training to apply these principles in practice. The trainer confirmed the staff had Mental Capacity training annually; however, the delivery of the training was short as it was part of two days where all required mandatory training was covered.

The provider had a policy regarding the Mental Capacity Act, which in the main covered DoLS. This was not relevant to this service area as it was generic and all the patients at Bradley Woodlands were detained under the Mental Health Act.

The deputy manager and Mental Health Act administrator, who was also responsible for the Mental Capacity Act (MCA), had good knowledge of the MCA assessment process and principles. They had started a planned programme of assessment, covering instructing a solicitor for a hearing and agreeing and signing 'my shared pathway' plans. As this was at an early stage the

named nurses were not yet routinely involved. However, the provider should note this legislation has been in place for ten years and practice needs to involve those closest to the patient.

There was evidence of questions and patient's responses to questions during a Mental Capacity Act assessment. This was clear and language used reflected the patient group. We saw revisiting to assess retention of information.

The deputy manager and mental health act administrator initially completed the form for a best interest decision. This was then shown to the patient's key nurse for their agreement. The best interests decision was then taken to the multidisciplinary meetings where carers were not routinely invited. This did not meet the guiding principles of the Act.

Staff did not fully understand their individual responsibilities in relation to the Mental Capacity Act. Their comments demonstrated this. Staff told us that it was not their responsibility to undertake Mental Capacity Act assessments. We heard reference to it being "management's role". Staff could not talk through examples of the use of the Mental Capacity Act in their work. They saw it as someone else's responsibility.

Six staff nurses spoke of a lack of understanding at a basic level of the application of the Mental Capacity Act in practice. Staff made some decisions without capacity assessment or best interest decisions. We saw evidence that family members were routinely involved in care programme approach meetings. However, this was not the case at multidisciplinary team meetings where best interest decisions were agreed.

Formal Mental Capacity Act documentation was available and appropriate. Staff did not use a consistent approach to using this documentation. A number of the patients lacked capacity in more than one area and staff were making decisions on their behalf without the legislative framework. We were concerned about the lack of emphasis on this area in view of the needs of patients. We raised these concerns with managers at the end of our inspection.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Requires improvement

Forensic inpatient/secure wards

Safe	Requires improvement
Effective	Requires improvement
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

The two wards, Willow (female) and Maple (male) consisted of separate apartments built around a central secure courtyard. Gender specific apartments were next to each other, with male and female sleeping areas segregated. Every patient had his or her own bedroom. All rooms had ensuite toilet facilities. Access to the courtyard was provided for patients subject to an individual risk assessment, support workers ensured the mix of patients in the courtyard was safe.

There were bedrooms within the apartments where patients were not in the immediate line of sight of staff which is permitted in low secure settings. The layout of the apartments, similar to a small shared flat, aided rehabilitation. At least one member of staff was on duty in each apartment at all times. An alarm system linked the apartments to the nurse's station. If an incident occurred and the alarm was raised, staff would make individual decisions as to how to respond, using the range of safety related resources available.

There had been an incident where response staff could not open an apartment door as a patient had sat on the floor behind it and blocked it. This trapped a support worker and patient in the apartment. This incident had led to heightened anxiety for some support staff. The senior management team at the hospital were aware of these concerns and offered additional support to staff. The doors are an identified issue on the risk register under an environmental refurbishment with an expected completion date of September 2015.

Staff nurses described feeling safe. However, five out of seven support workers raised concerns about their safety while working alone in apartments. The hospital mitigated this by identifying staff on each shift able to move between apartments when needed. There was an alarm system active across the site with a designated response team on each shift. Staff also carried radios, to request assistance.

Four patients told us they felt safe in the apartments, because they know what to do and that staff would act if affected by the behaviour of others. Two patients told us they did not feel safe. They described sometimes feeling threatened by other patients in the apartment and no one helping. This was discussed with the deputy manager to ascertain the correct procedures were followed. The other five patients we spoke to did not comment on their safety.

There was a contraband list on the wall in reception and within the patient information leaflet. When patients returned from unescorted leave, staff searched them in line with policy. Any contraband items were retained by staff as property belonging to the patient and returned to the patient on leaving the service.

Support staff told us that the temperatures in apartments were too high in summer and too cold in winter. The senior management team discussed these concerns at the hospital planning meeting. Thermometers had been placed in the apartments and temperatures were being recorded daily to collect evidence for the board. To ensure good air circulation on hot days staff were opening windows and doors.

Requires improvement

Forensic inpatient/secure wards

There was a dedicated physical health room with a couch, a blood pressure monitor and scales. However, the hand washbasin in the clinic room had separate hot and cold water taps. This prevented water reaching an optimum temperature for hand washing and was not in line with the health and social care act 2008 code of practice on the prevention and control of infections. In the refurbishment of the clinic room this was to be rectified. Staff checked the emergency equipment daily. The equipment was in date and had clearly identified expiry dates.

The maintenance team had responsibility for the maintenance of the environment, the housekeeper for cleaning. The resources needed to clean the hospital properly were all in place. We saw evidence that regular cleaning took place. Alcohol hand gel was available at ward entrances and throughout the wards. Support workers also had a role in cleaning, alongside patients if possible, in their apartments.

The seclusion room was not in use at the time of our inspection as a patient no longer at the hospital had damaged it. The absence of a seclusion room was high on the provider's risk register. The planned refurbishment was due to address this. The upgrade of this room was due to be completed by September 2015. No admissions were being planned until the seclusion room refurbishment was completed.

In the absence of a seclusion facility, measures to mitigate risk were based around individual patient risk assessments. These identified staff relationships with patients, knowledge of specific triggers and staff's ability to de-escalate situations. However, if seclusion was required during this time, there was no facility available but the provider informs us that seclusion has been used only once in the last five years and that it had agreed not to admit any new patients until the refurbished seclusion facility was in place.

The clinic room was clean, tidy and well organised. There was a daily record of fridge temperature checks. Medication was stored and administered safely. Patients received their medication by attending the clinic room at a time requested by nursing staff. No patients were considered able to self-administer medication at the time of our inspection.

There were ligature points throughout the apartments. A ligature risk audit in March 2015 highlighted the need to replace certain furniture, fittings and hinges. This was on the risk register but with no timeframe. Other actions to reduce risk, such as staff awareness, care planning and managerial controls, were in place.

The balance between rooms being homely and ligature-free was a consideration for those patients preparing to leave hospital. Decisions about personal items and televisions and radios in patients' rooms being boxed in for safety (or not) had been made based on individual risk assessments.

One patient's room contained only a mattress and a locked cupboard to mitigate a high risk of ligature. However, in this room there were curtain rails and a doorframe both of which were ligature risks. Through an adjacent open door was the room of another patient that contained a number of items that the patient could have used to self-harm. When asked about this situation a member of support staff clearly told us in front of the patient that they knew they had to "earn the right" to have their personal items back. The deputy manager was party to this discussion and did not challenge these words. We were unable to check this with the patient. The intervention was care planned and linked to behaviourally managing risk. However, while working within the guiding principles of the Mental Health Act 1983 Code of Practice some psychological treatments or programmes may impose restrictions on normal day-to-day activities; access to a comfortable environment should never be restricted or used as a 'reward'.

Safe staffing

Key Staffing Indicators

Establishment levels: qualified nurses (WTE) **17**

Establishment levels: support workers (WTE) **77.7**

Number of vacancies: qualified nurses (WTE) **0**

Number of vacancies: support workers (WTE) **7%**

The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies over the 3 month period May – July 2015 **137**

The number of shifts filled by current workforce to cover sickness, absence or vacancies in 3 month period **506**

Requires improvement

Forensic inpatient/secure wards

The number of shifts that had NOT been filled by bank or agency staff where there is sickness, absence or vacancies in 3 month period **53** however, the hospital manager, deputy manager and lead nurse were available at these times to provide additional support and input

Staff sickness rate (%) in 12 month period **Qualified 10.7% Unqualified 5%**

Staff turnover rate (%) in 12 month period **Qualified 1** (WTE) **Unqualified 20.2** (WTE)

The hospital used a matrix tool to calculate the required staffing levels based on need. This allowed allocation of resources based on both patient numbers and their required levels of observation. Minimum staffing levels for Maple and Willow wards combined were three or four qualified nurses during daytime and two at night, with 16 unqualified staff daytime and 14 at night. The lead nurse monitored compliance with minimum staffing.

The lead nurse calculated the staffing requirement daily based on the number of patients and their required levels of observation. We looked at figures for staffing over a three-month period. During the day, we found three or four qualified nurses on duty, which dropped to two on five occasions and 15 to 18 support workers, which dropped to 14 on one occasion. At night, there were two qualified staff members, this dropped to one member of staff on two occasions, and 13 to 16 support workers, which dropped to 12 on one occasion. The hospital had used overtime, or regular bank or agency staff to cover vacant shifts.

Staffing rotas confirmed an increase in staff was possible, and would occur to accommodate increased need. Additional resource came from overtime, bank or agency staff. Recruitment and retention of unqualified staff was a challenge for this provider in this geographical area. Current staff often worked additional shifts. Senior management team and the board were looking at the recruitment and retention of new staff.

Registered nurses learning disability (RNLD), registered nurses mental health (RNMH) and registered general nurses (RGN) made up the qualified nurse staffing team. There was always at least one RNLD on each shift.

Five out of seven support staff and three out of six staff nurses believed there should be two staff in each apartment for safety as had previously been the case. Patients did not comment on this change and we were not able to measure its impact. At the time of inspection, some apartments had one support worker. There were other support workers on duty in the apartments with a role to support their colleagues if required. Radios were available to request assistance. The response team was also available through the alarm system. Whilst acknowledging these measures, two support staff still expressed their vulnerability when working alone in an apartment.

Patients expressed their concern that staff cancelled some section 17 or “home leave”, or that staff asked them to visit other apartments to free up staff to cover this leave. Three patients told us they had had leave cancelled on Friday 10 July, as no response team would be available if this went ahead. Staff expressed concerns that shifts were changed at short notice, which sometimes meant working days and nights in same week. We looked at rotas and discussed this with the lead nurse. They told us there was a need for flexibility within the rota system to meet the changing needs of the patients. However, where possible, rotas avoid staff working days and nights in the same week.

Staff raised concerns that they were unable to take breaks on a 12.5 hour shift without leaving staffing numbers low. When checked a main break was available to staff on a 12.5 hour shift, but individuals often chose not to take this. Breaks seemed of particular concern in relation to the proposed no smoking throughout the site that the provider was contractually required by NHS England to introduce by 1 April 2016. When introduced staff would be required to leave the site to smoke. The senior management team understood there were many concerns as they worked with staff and patients towards smoking cessation on site.

Out of hours cover for the consultant psychiatrist was provided over the telephone within Lighthouse. This was on a four out of five a week rota system. Another Lighthouse psychiatrist provided cover for the consultant psychiatrist when on planned leave.

Staff compliance rates for mandatory training at Bradley Woodlands were 73%, against a hospital target of 90%. Mandatory training for staff took place on induction. This included health and safety, infection control, fire, manual handling, control of substances hazardous to health (COSHH), information governance, basic and intermediate life support, safeguarding, searching patients, and Mental Capacity Act (MCA) and Mental Health Act (MHA) training. Mandatory training for staff was updated annually.

Requires improvement

Forensic inpatient/secure wards

Staff completed four-day stand-alone conflict management training, with a focus on de-escalation. All clinical staff were required to update this training annually. Following a recent course staff told us they were more confident in using appropriate verbal de-escalation to manage incidents. We found one qualified staff member had no training in resuscitation. We informed the training manager who confirmed they would treat this with priority.

Assessing and managing risk to patients and staff

We reviewed 14 sets of care records. Risk assessments were present in all. The risk assessment tool completed for each patient was the historical clinical risk assessment (HCR-20). Patients' care plans followed the recovery-based approach 'my shared pathway'. There was evidence of patient views in eight out of the eleven care plans we reviewed. There was a clear message from management to the staff team to use the least restrictive option however, this was not always reflected in the care plans seen. Risk management plans were in place with staff relationships with patients, knowledge of their triggers and use of de-escalation techniques identified to mitigate risk.

The senior management team had the option to refuse those patients referred for admission who posed a high risk to staff and/or other patients referred at Bradley Woodlands. This decision was made following a pre-admission assessment.

Staff undertook medicines audits quarterly. A full contract with a new pharmacy was due to begin on 1 August 2015. Ahead of this change under a transitional arrangement, the new pharmacist had completed an audit of medicines. Discrepancies found between the patients notes and medicine cards had been resolved. There was an agreed training plan for qualified nurses on 23 July with the aim of reducing the use of as required medication. We reviewed medicine administration errors/incidents for 2015. The senior management team investigated all incidents. For each incident monitored action plans were in place, with their progress discussed at clinical governance meetings.

Prescription charts were clearly written, appropriately signed, with side effects and allergies listed. All certificates of consent to treatment (T2) and certificate of second opinion (T3) forms for detained patients were in place. There were separate medicine trolleys for each ward. There was only one controlled drug used and appropriate checks were in place.

Staff have only used seclusion once in the last five years, for a period of three hours. The review of seclusion records found that they were in line with hospital policy. The seclusion room on the day of inspection was out of use as a patient had damaged it in June 2015 when last used. Plans to refurbish the seclusion room were in place with a reported timescale for completion the end of September 2015. While the space within the building layout lends itself to managing people without the need for seclusion, there was no provision for seclusion should the need arise. Management regarded the work on the new seclusion room as a priority.

There were 323 incidents of physical intervention by staff recorded from December 2014 to May 2015. Staff never needed to administer rapid tranquilisation during these incidents. Staff could give a definition of restraint and knew how to report it. We saw nine documented incidents recorded as prone restraint where patients had put themselves into the prone position. We reviewed restraint records and found high figures relating to certain individuals for behaviours that repeated. A manager reviewed reported incidents, this included discussion about how an incident might be managed differently. Debrief was offered to patients and staff involved in any incident of restraint.

Patients knew they could talk to staff or the advocate if they were worried. Staff knew they had a responsibility to safeguard the patients in their care. Staff described how they would report any safeguarding issue to a manager. The deputy manager took a lead in reporting safeguarding to the local authority. She was confident that all staff knew what constitutes safeguarding and what needed reporting. The quality manager reviewed any safeguarding issues raised and attended external meetings.

Senior managers spoke of good relationships with the local authority safeguarding team. The system for reporting to them included monthly reports of safeguarding concerns. Since June 2014, there had been 56 safeguarding concerns. North East Lincolnshire adult safeguarding team confirmed they had good communication with this provider around referrals and queries.

Track record on safety

Senior management and the multidisciplinary team (MDT) reviewed serious incidents. There was a peak in incidents in May 2015 following the placement of a patient whose

Requires improvement

Forensic inpatient/secure wards

needs could not be appropriately met within this low-secure environment. Transfer to a more suitable medium secure placement took place. Lessons learnt following a review of the hospital's admission process included a more detailed pre-admission assessment.

Reporting incidents and learning from when things go wrong

All staff understood the need to report incidents. Staff completed paper incident forms after which administrative staff then transferred them to an electronic system. Managers reviewed all incidents, the electronic system allowed patterns of incidents to be easily seen for example, time of day or location.

There was training for staff on de-escalation and management encouraged staff to focus on positives when dealing with incidents. Changes to a long established shift system were being made with the aim of increasing learning from incidents through wider staff discussion.

The nurse in charge ensured debriefs following incidents happened on the same day. Debriefs were for both patients and staff. Staff reported and recorded accidents or injuries, whether to staff or patients.

Staff categorised all incidents against the provider's policy. The level attributed to the incident determined who then investigated what had happened. Management reviewed all serious incidents. We saw minutes of internal meetings with lessons learned shared with staff.

For the month of June 2015, staff reported and logged 97 incidents. We saw evidence of actions going forward from these. The quality lead looked at trends and themes from incidents including location and time of day. Management reviewed incidents monthly at the clinical governance meeting. This fed into the bi-monthly regional managers meeting, which reports to the chief executive officer. Following a serious incident, an incident analysis meeting was held; the minutes showed the actions agreed. Learning from incidents took place at an organisational level through meetings. Information was fed down to staff at internal meetings. The provider was aware that staff attendance at these meetings was low and was taking action to increase attendance.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed 14 care records and spoke to 11 patients. Following a pre-admission assessment, staff completed a full assessment on admission. For the first 12 weeks following admission, staff saw patients and considered their care weekly at the multidisciplinary team (MDT) meeting. After this, they saw patients at this meeting a minimum of monthly. Qualified nurses listened to support staff who contributed to care planning. Named nurses could request cover to ensure 1:1 sessions with patients to review care happened. Every patient had an individual care plan completed by nursing staff. Eight of the care plans we reviewed were holistic and showed evidence of patient's views three did not. Behavioural expectations and interventions were clear. We attended a multi-disciplinary meeting where minutes were taken. The timescale for actions related to interventions discussed was not clear.

On admission, the GP undertook a physical health check and examination. All patients had physical health action plans. A GP and practice nurse covered the physical healthcare of patients after admission. We reviewed eight physical health records; staff had completed them as appropriate. The absence of internet access meant the practice nurse who visited weekly could not access patient records held on the GP's electronic system from the hospital. However, the provider gave the practice nurse notice of the visit on the day before so she is able to access the patient records and print these off at the GP's office before visiting. When patients needed to be seen because they had become a priority lack of access to electronic records could be difficult.

The psychiatrist and pharmacist checked drug charts monthly for contraindications in prescribing. In line with the national institute for health and care excellence (NICE) guidance, the psychiatrist had worked with patients to reduce high levels of medication, all four carers we spoke to commented positively about this.

Systems on the wards were paper based. Staff stored patient's main files in the nursing office with individuals

care plans available in the apartments. This was due to change in August 2015 when management were introducing an electronic system with the aim of enhancing care through improved communication.

Best practice in treatment and care

Staff completed health of the nation outcome scales (HONOS) on admission and repeated this as an outcome measure for each patient. They followed the national institute for health and care excellence (NICE) guidance on observation and medication. We saw evidence of regular audits of certificate of consent to treatment T2 and certificate of second opinion T3 forms.

My Shared Pathway was in use to increase patient involvement in their care. Work was at an early stage to implement positive behavioural support in response to department of health guidance on positive and proactive care. When fully implemented this would support positive risk taking and consistency in care.

Staff identified greater consistency across shifts as something that would improve the lives of patients. There was a long-standing two-team shift system, which is in the process of being altered with the aim of enhancing care.

Engagement in meaningful activity was something highlighted as important to the care and rehabilitation of patients at Bradley Woodlands. We saw a programme of activities and a range of equipment for delivery of these activities.

We heard a great deal from patients, carers and staff about activities within the service. The activities identified at the presentation and those we saw on patient's individual lists differed. This was because the presentation provided examples of the full range of activities that patients could undertake. Having heard from patients their preferences were not always possible, we discussed this with the activities co-ordinator. We were told that this was not true, and that the issue was that some patients were easier to motivate than others. Staff told us laundry and apartment shopping counted as meaningful activities on the basis people enjoyed doing them. The provider informed us that these were important activities, essential in building patient's life skills and in maintaining a normal routine while patients were at the hospital. Both patients and staff talked about the choice of activities being limited and planned activities were often changed or cancelled. Over a three-month period, out of 637 planned activities 186 did not occur, of these 68 activities were not available for resource reasons.

Skilled staff to deliver care

Qualified nurses and support workers provided 24-hour care at Bradley Woodlands. The wider team included a two activity coordinators, a psychologist two days a week, two psychology assistants and a consultant psychiatrist. The pharmacist, GP and practice nurse visited regularly. Staff could make referrals to other professionals locally including a speech and language therapists. There was no social worker or occupational therapist at the time of our inspection but the provider told us that they had already interviewed for the social worker position and that the occupational therapist was unavailable.

Staff told us mandatory training, supervision and appraisal made a positive difference to their practice. Seven of the eleven ward staff we spoke to said they would like to develop more specialist communication skills and knowledge of positive behavioural support to enhance the quality of care they could offer. A new member of staff reflected on a good induction, which involved two weeks training after which they remained supernumerary for a further four weeks, which allowed time to get to know patients, colleagues and systems.

In line with the provider's policy, all staff received quarterly supervision and new staff had monthly supervision during their probationary period. The service was working towards increasing the support through monthly supervision for all staff.

Staff working bank shifts received supervision. Management supervised and supported administrative staff. Two members of this team told us supervision was supportive and effective. The psychologist at Bradley Woodlands attended monthly peer supervision.

We spoke to seven support workers who all communicated a commitment to delivering good care. They would like more training that covered specific issues that individuals in their care experienced, for example bereavement work. Three carers were surprised that whilst senior staff knew the history and diagnosis of patients in their care, support workers, who spent the most time with their relative, knew so little of the background of the people they cared for. They saw this as important, if they were to effectively

meet people's needs. Three of the support workers we spoke to knew the history of most of the patients in their care two said they did not. The layout of the ward may contribute to this. Patient's main notes, which include this background information were kept in the nursing office which couldn't easily be accessed by support workers during shifts. However, copies of individual care plans were kept in the patient's apartment and were accessed by support workers.

One of the changes staff identified following the new management approach was that the patients engaged more in thinking about their future. The service also supported them in more positive risk taking.

Multidisciplinary and inter-agency team work

Within the multidisciplinary team (MDT), psychiatry and nursing were well-represented at the time of our inspection, there was access to an advocate, and speech and language therapist. There was no social worker within the team but the provider had interviewed for the post and hoped to be able to offer four to six sessions a week. The psychologist was at Bradley Woodlands four sessions a week whilst the recruitment of a full time forensic psychologist was underway. The psychologist supervised assistant psychologists allocated to individual patients. In the absence of an occupational therapist there were two activity co-ordinators supporting work with patients.

MDT meetings were held weekly, with each patient discussed a minimum of monthly. We attended the MDT meeting for three patients. Staff always invited the patients and, if they were able to, relatives could attend. Discussion covered what assessments were required, medication changes and progress made. When possible the named nurse attended the meeting with the patient. What was described as a 'movement towards' positive risk taking was part of the decision making process within MDT meetings.

Staff planned care programme approach (CPA) meetings in advance and encouraged patients and relatives to attend. We observed a CPA where relatives and the patient's external social worker were part of the process. There was nursing and medical input at this meeting but no psychology or occupational therapy. However, we were told when available these staff members attend. The inter-agency working we saw was effective.

There was a contract for the practice nurse to visit weekly and the GP monthly for physical health monitoring. The GP was also available at the practice if urgent health needs arise.

There was a positive relationship with North Lincolnshire safeguarding team who took referrals and supported investigations. Management told us the local police would attend an incident and respond sensitively if called.

Adherence to the MHA and the MHA Code of Practice

We reviewed the detention documentation for all the detained patients. The use of the MHA was good with detention documentation complying with the Act and code of practice. The provider had a Mental Health Act administrator who completed audits and scrutinised documentation. Staff felt supported by this and we saw an efficient and effective range of systems to support nursing and medical staff in meeting the responsibilities of the Act.

MHA training was incorporated into the induction and clinical staff attended annual refresher training. Staff shared Information on the rights of patients verbally and in a variety of written and pictorial formats.

Staff filed completed consent to treatment forms with prescription charts. All T2 and T3 forms were in place and matched the drug charts.

The provider had access to an independent mental health advocacy service with a private room for patients to have a private discussion. There was advocacy for all patients who lacked capacity and we saw attendance at relevant meetings. Over a three-month period, they facilitated 95 individual contacts, saw 190 patients at 'drop-in' sessions and an advocate attended two community meetings.

Patients who were able to understand their rights confirmed that staff regularly discussed these with them. Those who could not understand continued to have their rights repeated to them. Staff used pictorial and easy-read formats to assist in communicating the information and could seek the assistance of the advocacy service in order to ensure that patients understood their rights. However, staff told us some patients would never understand their rights but had this information read to them weekly anyway.

Requires improvement

Forensic inpatient/secure wards

Requests for section 17 leave were agreed at MDT meetings, typed the same day, and signed by the responsible clinician. Section 17 leave forms were clear and struck out or ended after review.

Good practice in applying the MCA

Staff had received mandatory training in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff told us this training was limited to an overview of the principles. Four qualified nurses told us they required more training to apply these principles in practice. The trainer confirmed the staff had Mental Capacity training annually; however, that whilst application to practice was discussed in the training room delivery time for this update was short as it was part of two days during which all required mandatory training was covered.

The provider had a generic policy regarding the MCA, which in the main covered DoLS. As all patients at Bradley Woodlands were detained under the MHA, it was not relevant to this service area. Formal MCA documentation was available and appropriate. We did not see a consistent approach in using this MCA documentation. When reviewing case notes, we found no assessments of capacity in section 4. In view of the needs of the patient group, there was a lack of emphasis on this area.

Management and the MHA administrator demonstrated good knowledge of the MCA assessment process and principles. They had started a planned programme of assessment regarding two areas for all patients. The instructing of a solicitor for a hearing and patients agreeing and signing 'my shared pathway' plans. This was at an early stage; however, named nurses were not routinely involved. Staff believed patients with a certain amount of savings had to fund a solicitor for tribunal hearings. This was incorrect as all patients are entitled to a solicitor for tribunals free of charge.

We saw evidence of questions and patient's responses to questions during a MCA assessment. Staff used clear language appropriate to the patient group, revisiting to assess retention of information.

Staff were unclear about their individual responsibility in relation to the MCA. They demonstrated this by their comments. Staff told us that it was not their responsibility to undertake MCA assessments. We heard reference to it being management's role. Staff were unable to talk through examples of the MCA in their work. They saw it as someone else's responsibility. At multidisciplinary meetings, best interest decisions were completed. At the time of our inspection, there was no social worker in post as part of this team.

There was a lack of understanding at a basic level of the MCA. Patients who lacked capacity received care and interventions with no legal framework. Staff made decisions without capacity assessment or best interest decisions. It was unclear where family members were involved. Staff had a lack of understanding of the role of an independent mental capacity advocate.

Are forensic inpatient/secure wards caring?

Requires improvement

Kindness, dignity, respect and support

We observed some caring interactions from staff who clearly knew the patients. However, staff did not always speak about or to patients with dignity and respect. For example, we observed one support worker say to another "can you keep an eye on these" during a smoking break in the courtyard.

We observed comfortable and familiar staff/patient interaction in the reception area of the hospital. We also witnessed a reasonable request made to a staff member, which was deflected rather than responded to.

Managers believed patients could make telephone calls in private. We were told some patients were risk assessed at their multidisciplinary team meeting to have their own mobile phone. Five of the eleven patients we spoke to told us that when making calls staff listened in. One was concerned that the acoustic hood over the payphone designed to afford privacy to the user did not do so.

We saw one patient with only a mattress in their room. Staff removed their belongings following a violent incident. The contrast between their room and the adjacent room, which could be seen by the patient, was notable. This intervention was care planned to manage risk behaviourally. However, the support worker with the patient told us in front of the patient that they knew how they had to 'earn back' their belongings. The patient did not comment. Working within the guiding principles of the

Requires improvement

Forensic inpatient/secure wards

Mental Health Act 1983 code of practice, restrictions should be reasonable and proportionate. Access to a comfortable environment should never be restricted or used as a 'reward' dependant on desired behaviours. Managers were aware of this situation. In the management of this patient we were told staff were looking for indications that any risk posed by the patient was diminishing.

The involvement of people in the care they receive

Staff pre-planned admissions and this included orientation of new patients to the ward. Patients told us staff spoke to them about planning their care. Four patients showed us a copy of their care plan. Other patients told us the staff supported them to make decisions about day-to-day activities.

Care plans were present in the main care records in the nurse's office. Of the eleven care plans reviewed in detail, eight showed patient involvement, three did not. Support workers could read copies of individual care plans in the patient's apartment.

CPA's and patient reviews inform care planning. One patient talked about chairing their own review. We attended a CPA meeting at which staff reports were available in advance. Parents and an external social worker were present; staff sought their views. The meeting reflected on the impact of previous changes to care and agreed a detailed treatment plan. Minutes recorded the outcome. The patient had chosen not to attend their CPA; however, there were members of the MDT present who knew them. Feedback from this meeting about a forthcoming discharge was not to be given to this patient until it was about to happen. Staff and relatives were concerned discussion about this planned discharge might result in the patient's health deteriorating.

We spoke to four carers about the care of their relative. Relatives could telephone to make an appointment to visit but could not enter the apartment. Carers have wanted to see their relatives' room for a very long time and never been able to. Management said this might change. The provider informed us that as this is a low secure unit, it is not always appropriate for carers to visit the apartments both from the perspective of potential risk to the visitor and confidentiality. However, there were facilities available that supported visiting. Events took place on site to which family/carers were invited.

Each patient had 25 hours of 'meaningful activity' weekly. However, this included laundry and apartment food shopping, considered meaningful by staff because patients liked them. Most of the patients we spoke to would like a greater choice of activities.

Patients were part of the staff interview process. Four or five patients attended Yorkshire and Humber network meetings. A patient, with support from the advocate, chairs monthly community meetings with management.

We attended the patient involvement forum where a member of staff treated the patient chairperson disrespectfully. The staff member spoke in an authoritative way, cutting across the chairperson, loudly repeating rules and reminding them about having forgotten something that had been said at previous meetings in a way that seemed to make the chairperson uncomfortable and upset. We spoke after the meeting to the staff member concerned who seemed unaware of the impact of their behaviour. At the smoking cessation meeting, we witnessed positive patient engagement. However, a support worker had a radio on loudly which broadcast periodically throughout this meeting.

We fed back to the management team concerns that the values of some staff were compromising the aim to deliver person-centred care.

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

Requires improvement

Access and discharge

The bed occupancy at Bradley Woodlands over the three months prior to our visit was 91%. Following a referral there was a pre-assessment meeting, which involved qualified nurses and managers. This process involved meeting the patient and their carers. Staff then reported an assessment of suitability to the MDT. If a patient's needs could be met by this hospital, their admission was planned. If following pre-assessment an individual could not have their needs

met by the service there was a right to refuse admission. Staff told us that before a patient arrives, the named nurse had an admission plan, which they communicated to the staff team.

Staff presented a welcome pack to new patients with information about their key worker, their apartment, assessment process, their rights, what the hospital offers and its rules. This was an easy read document. Staff support patients to understand its contents if needed. Managers increased staffing to facilitate a successful admission and support changes in the wards.

Patients admitted to Bradley Woodlands in the last year had their progression and discharge considered from the point of admission. Most patients became involved in their CPA reviews at which there is detailed consideration of future needs with a focus on discharge planning. The aim was an open dialogue with relatives, the patient's care co-ordinator and any future care provider. When the multidisciplinary team are considering a specific discharge date, staff put in place transition planning, which included psychiatric follow-up.

For those patients admitted when the Bradley Woodlands was a long stay rehabilitation unit discharge planning had not commenced on admission. Some of these patients found discussions about discharge planning very challenging. We heard from staff and carers that individuals have experienced deterioration in their mental health when faced with moving on. The patient who had the longest stay had been admitted in 2004. Bradley Apartments, on the same site, was available for transition but these were not homes for life.

Ahead of discharge, staff supported patients to visit the places to which they may go. We spoke to one patient who was involved in discharge planning. Both the patient and their relative had been disappointed when staff had told them a step down placement the patient had liked after visiting was too expensive. Finding suitable placements to meet the needs of patients moving on was described as challenging by patients, carers and staff. The availability of suitable placements was outside the control of the provider.

The facilities promote recovery, comfort, dignity and confidentiality

Bradley Woodlands has extensive quiet grounds. There was a maintenance team, a gardener and a housekeeping service to keep up the facilities. There was disabled access throughout.

The reception area was welcoming, with names of hospital managers and first aiders clearly displayed. Visitor rooms and the advocacy office were private and available for use away from the ward area.

The environment was clean however some apartments appeared shabby and in need of re-decoration. Staff explained that there was a plan to do this, which included new furniture. Management described specific challenges in improving the ward environment because of the disruption it could cause.

Many rooms were personalised and accessible during the daytime. Patients could choose the decoration in their own room. We saw some personalised spaces. If a risk assessment highlighted specific concerns, staff removed items from bedrooms. Other rooms in apartments were bare of pictures and personal effects. Staff told us, in these cases, items would be replaced following redecoration. It was unclear how long rooms had been in need of redecoration, however, the environmental refurbishment was due to be completed by September 2015, and It was rare that patients moved from their room unless the dynamic in an apartment was detrimental to the patient's recovery.

All bedrooms remained unlocked during day. Staff told us individuals could have keys to their own room if risk assessed and agreed at MDT. We saw no risk assessment relating to keys and did not speak with any patient who had a key to their bedroom.

Outside there was an allotment area where patients could help to grow produce for meals. Weekly menu planning took place in apartments. Staff shopped for the food, when possible with the patients. This was prepared in apartment kitchens. Each apartment had drinks available. To support a request for air-conditioning, staff recorded temperatures daily following reports of apartment kitchens being too hot in summer and too cold in winter.

Outdoor space at Bradley Woodlands was secure, extensive and well maintained. Five patients' spoke of wanting to be outside more. The courtyard was used for set smoking breaks which presented opportunities for patients to leave their apartments whether smokers or not. Patients who

liked walking told us they could sometimes do this round the courtyard. Two patients told us they used to go out walking in the larger secure garden but could not do this now as there were not enough staff. Patients who were part of the gardening team spoke of wanting more time out in the garden than they had. The co-ordinator planned offsite activities for patients a minimum of once a week Those who went out from the hospital with staff enjoyed these activities.

We heard loud sounds from bunches of keys in regular use and doors banging frequently while in the ward environment. Three patients said it was too noisy.

There was a large activity room, which could be divided into two rooms. It had cooking facilities for patient use. Staff put up on the walls artwork created there. The laundry was available for patients to use as part of their rehabilitation. Patients had access to a large gym with a range of equipment. However, management restricted its availability at times, as staff training also took place there.

A new sensory room was available. This required patients to undergo individual risk assessments prior to use. However, only certain staff had access to keys for the room limiting its access to patients who might use this facility.

Patients said there was not enough to do and that if they missed the Monday meeting then staff gave them 'just anything'. The provider informed us that staff make a particular effort to encourage patients to get up to attend the Monday morning meeting. We saw individual activity plans, which included apartment shopping and laundry. Patients and relatives said staffing levels do not allow for the delivery of activities at weekends. The provider told us that some patients prefer not to participate in activities at the weekend, or to participate in fewer activities, and that the number of activities that take place at the weekends is not limited by staffing levels.

Patients also said that staff cancelled activities due to staff shortages. We found over a three-month period that staff had cancelled 68 activities due to lack of resources. Over a 12-month period, of 1,768 section 17 leaves planned, 1,136 took place. Of those that did not take place the patient cancelled 109, staff cancelled 226 for clinical reasons and 17 did not occur for other reasons, such as bad weather, visits from outside agencies or transport not being available. Two hundred and eight are unaccounted for. These figures were checked post-inspection with the service manager.

Meeting the needs of all people who use the service

We attended the weekday morning meeting, which promoted communication between the wards and senior team. The meeting covered staffing levels, incidents, and queries from patients brought by managers. It was clear all the staff involved in this meeting knew the patients well.

Staff made available for patients easy read text and pictorial leaflets about aspects of their care. Management told us they gave out most information about treatment verbally and repeated it if needed to be understood. They told us that they were working towards easy to read care plans. Whilst there was some support for patients in their communication, we did not see support tools in use specifically to meet individual needs.

Patients at Bradley Woodlands have held two successful charity fundraising events. There had recently been an Eid Festival to mark the end of Ramadan.

Listening to and learning from concerns and complaints

There was limited information on display about ways to complain, access to advocacy or how to contact the CQC. Staff told us patients had information on how to complain in their information pack, however they gave this information out on admission and some patients had been at Bradley Woodlands for a number of years. Five patients knew how to complain verbally to managers and the advocate. Patients could raise issues or concerns on a daily basis as the deputy manager walks around the apartments. The provider told us patients could also provide feedback in forum and community meetings. We heard issues raised by patients discussed at the daily morning meeting. Staff told us they investigate complaints and write to the individual concerned; however, not all patients would be able to access information in this format.

Whilst most did, not all staff caring for patients had knowledge and understanding based on their individual life history. Three carers were particularly concerned about the limited information support staff seemed to have about the background of the patients in their care.

Requires improvement

Forensic inpatient/secure wards

The hospital manager and deputy manager handled all complaints. There were 21 formal complaints made in 12 months prior to April 2015. Of these, the director upheld four .The hospital planning meeting discussed complaints. Management sent out letters to update staff or patients on progress.

Staff shared two recent examples of responsive practice: Following an incident where a patient had damaged the seclusion room, management reviewed the hospital's admission procedure. Concerns raised about staff attitudes in apartments led to a period of observation being undertaken by the quality lead.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

The weekly planning meeting had representation from a wide service team. Agenda items included maintenance, medication, housekeeping, finance, fire procedures, cancellation of activities and patient moves. These were standard agenda items. Management circulated minutes with action points for specific individuals.

The wider organisation supported the work at Bradley Woodlands, the manager experienced support from senior management within the organisation. There was a quarterly whole day meeting attended by senior clinicians, service directors and quality and compliance leads to cover a range of issues, including sharing best practice. Clinical governance and health and safety meetings took place regularly in the hospital and corporately.

Staff told us the culture had improved under the new management regime. They felt supported by management and had no concerns raising issues. Managers were more visible through visiting the ward areas daily.

The organisation's policies were group policies specific to the service provided by Bradley Woodlands Low-secure Hospital. Management were reviewing them at the time of our inspection. Management had already reviewed policies on observation, mitigation of risk and searching patients and staff described these as being more user friendly.

However, support workers were not able to refer easily to the policies/procedures of the Bradley Woodlands site as they were held on the intranet, which was not available from the apartments where they were based. Paper copies were available, but like the computers, these were in the ward office. We were informed that the electronic care notes system was due to be fully implemented by the end of August 2015, which would enable full access.

The management team put patients at the heart of this service. Key messages to staff have been to use the least restrictive option, justify all interventions and avoid blanket restrictions. Management were finding this challenging, particularly for patients and staff who have been in service for a long period. Some patients had positive involvement in the service, interviewing staff and attending external groups. However, it was not clear that carers were involved in service development.

Patients and staff discussed extensively the proposed smoke free site and they saw it as a challenge. We attended a smoking cessation meeting where five patients (one of whom did not smoke) and two staff members identified that 50% of staff and patients smoke. The provider told us that 9 out of 21 patients smoke which is 43%. The patients present were not happy about forthcoming smoking ban but accepted that they would have to put up with it. Smoking cessation workers were beginning to meet with patients to discuss practical measures and support. This service was also available to staff members.

Good governance

The business continuity, emergency plans and employers' liability certificate were all appropriate and in date. Senior management from Lighthouse Healthcare visited the site regularly.

The registered manager took lead responsibility for the risk register. Five of the risks identified on this register had clear timescales. However, those following the ligature risk audit all had timescales which required confirmation.

We reviewed five staff files, which contained appraisal, accident records, risk assessments, record of supervision.

The structure of annual appraisal linked to Lighthouse values. Management set goals and targets with staff at appraisal and then reviewed them within supervision. The management team were working to support and develop the staff team.

Requires improvement

Forensic inpatient/secure wards

Issues arising out of supervision informed training needs. All staff received quarterly supervision; the service was working towards this being monthly. During a probationary period, new staff had supervision monthly as a minimum.

The structure for supervision covers physical health and well-being, teamwork, patients, job satisfaction, support and recognition, training, appraisal action plan and any other business. We reviewed five supervision records, all of which had differing amounts of detail, reflecting individual circumstances.

There was a five-day induction programme for staff covering mandatory training. There was separate conflict management training. Clinical staff had refresher training annually. Lighthouse target for mandatory training was 90% Bradley Woodlands compliance was 73%.

Managers have implemented role specific training, e.g. for administrative and housekeeping staff. Clinicians have asked for specific training, they believed would improve the quality of care for patients. We saw evidence of this around autism, dialectical behavioural therapy and diabetes care.

Leadership, morale and staff engagement

We found a strong management commitment to the growth and development of staff; however, the practicalities of releasing people from shifts was challenging. Regular staff working overtime and bank or agency staff were used to cover staff training hours, but some staff struggled to attend when training occurred on their days off. To encourage attendance, management pay staff to attend training on their day off.

Support workers told us that different qualified nurses have different expectations of them and that some were not very visible when on shift though do come when called. Some support workers said they felt unsupported and isolated in the apartments. Others said they supported each other on shift.

Bradley Woodlands employs qualified nurses who are RNLD, RNMH and RGN. The registered general nurses do not take charge of shifts. Staff informed us about conflict and tension between staff nurses who are trained differently. We observed three qualified staff with different understanding of their remit and roles. Senior management were aware of this and were supporting staff to work as a team.

We saw managers and senior nurses in the ward areas. They were approachable and clearly known to patients. Staff told us communication with support workers had improved since management had begun to visit the wards each day. Management told us they offered additional support to staff following stressful situations. Management listened to staff and saw positive suggestions put into practice.

To improve communication management shared the rationale for decisions with the team. There were team meetings every six weeks; however, staff told us it was hard to attend when on shift because of low staff numbers. They did not want to come into work for a meeting when off shift. We identified communication with support staff as being of greater difficulty than with qualified staff, as management use email, which support staff could not access outside of the office when on shift.

During our visit, all grades of staff highlighted lack of breaks in the ward areas. Staff work 12.5 hour shifts. We found a discrepancy between managers telling us staff can take breaks and support staff believing they would leave colleagues shorthanded and vulnerable if they did this. Currently staff smoke in the courtyard with patients. We heard anxieties from patients and staff about the proposed whole-site smoking ban. This may have heightened staff anxieties around breaks, as they will need to take a break in order to smoke.

We heard recognition from the management team that there is a distance to go 'to be as good as we can be'. They believe the new management structure offers a good foundation upon which to build. The consultant psychiatrist reported a happy team with good relationships at senior level. An external social worker told us the new management have given more continuity in care.

Commitment to quality improvement and innovation

The introduction of positive behavioural support for all patients across both wards at Bradley Woodlands was at its very early stages. This development is in line with guidance from the department of health and the national institute for health and care excellence.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- There was a lack of understanding at a basic level of the Mental Capacity Act 2005. Staff made some decisions without capacity assessment or best interest decisions. We saw limited evidence that family members were involved. We concluded that staff did not fully understand the role of an independent mental capacity advocate.

  Formal Mental Capacity Act documentation was available and appropriate. Staff did not have a consistent approach to using this documentation. We were concerned about the lack of emphasis on this area in view of the needs of patients. A number of the patients lacked capacity in more than one area and staff were making decisions on their behalf without the legislative framework.

The provider must ensure that staff understand their individual responsibility in relation to the Mental Capacity Act 2005 and apply this in practice. A review of training, policy and application of the Act is required.

- Staff did not always treat patients with respect. We witnessed three incidents during inspection when staff did not speak to patients with respect.
- There was evidence that patients had limited choices around activities. Staff made decisions for them if they were not at the morning meeting, which did not always reflect their preferences. The physical spaces for planned activities were not always available, for example, staff training took priority in the gym. must ensure patients' preferences are reflected and their needs are met.
- Replacement of furniture, fittings and hinges highlighted on the ligature risk audit in March 2015 had no timeframe for completion. To maintain safety th do all that is reasonably practical to mitigate risks by completing work identified within a specified time.

Action the provider SHOULD take to improve

- Management need to improve on the target for mandatory training of 90%; staff compliance rate at the time of the inspection was 73%.
- Replace the hand washbasin tap in the clinic room in line with current guidelines.
- Increase the range of professions within the multidisciplinary team.
- Introduce
- Prioritise recruitment of registered nurses learning disability.
- Work with staff to feel safe to deliver effective care when on shift.

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 9 HSCA (RA) Regulations 2014 Person-centred care Patients had limited choices around activities. Staff made decisions for them if they were not at the morning meeting, which did not always reflect their preferences. The physical spaces for planned activities were not always available. This was a breach of Regulation 9 (3b)

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 Staff did not always treat patients respectfully when expressing their wishes and feelings. We witnessed three incidents during inspection when staff did not speak to patients with respect. This was a breach of Regulation 10 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There was a lack of understanding at a basic level of the Mental Capacity Act 2005. Patients were receiving care and interventions with no legal framework. Staff made some decisions without capacity assessment or best interest decisions. We saw limited evidence that family members were involved.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Replacement of furniture, fittings and hinges highlighted on the ligature risk audit in March 2015 had no timeframe for completion. This was a breach of Regulation 12 (2b)
	Formal Mental Capacity Act documentation was available and appropriate. Staff did not use a consistent approach using this documentation. This was a breach of Regulation 11 (2)