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

Ratings

Overall rating for this location

Are services safe?	
Are services caring?	
Are services well-led?	

Overall summary

- The management team checked and reviewed staffing levels. Managers could adjust staffing levels to meet the needs of the wards. However, when cover for shifts could not be arranged staff felt unable to meet all the needs of patients.
- When two qualified nurses were on duty during the day shift, staff felt under too much pressure to complete their workload and spend enough time in the apartments with patients and support workers.
- We observed staff who knew individual patients well, the staff and patient interaction we saw seemed familiar and comfortable.
- The patients we spoke to told us most staff cared, were kind and spoke to them nicely. However, two patients said that at times some staff looked for arguments and could be rude to them.
- Staff reported incidents. Staff reviewed and analysed incidents at a range of meetings across the hospital.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards		We inspected aspects of Safe, Caring and Well-led but did not rate these.

Summary of findings

Contents

Bradley Woodlands Low Secure Hospital

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Forensic inpatient/secure wards

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 patients 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.

Our inspection team

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

The team included three CQC inspectors and one specialist advisor with specialist knowledge in nurse management of forensic and secure services.

Why we carried out this inspection

The inspection was an unannounced focused inspection to follow up whistleblowing concerns. We specifically looked at: how the hospital supported patients and treated individuals with dignity and respect, safe staffing, the reporting and learning from incidents, staff morale and engagement.

We have not rated Bradley Woodlands low-secure hospital at this inspection.

How we carried out this inspection

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

We asked questions of the service relating to:

- Is it safe?
- Is it caring?
- Is it well-led?

During the inspection visit, the inspection team:

- visited both wards at the hospital site during the day and at night and observed how staff cared for patients
- spoke with six patients who were using the service
- attended an activity group involving four patients
- captured the experiences of patients who may have cognitive or communication impairments using the short observational framework tool for inspection
- spoke with the divisional director, registered manager, deputy manager and lead nurse
- spoke with four qualified nurses on both day and night shifts
- spoke with 17 support workers on both day and night shifts
- reviewed notes written by support workers in each patient apartment across a 24 hour period
- completed a detailed review of staffing including rotas and allocation sheets
- reviewed incidents and staff mandatory training
- spoke to the external adult safeguarding team.

Summary of this inspection

Information about Bradley Woodlands Low Secure Hospital

At Bradley Woodlands low secure hospital there were two wards, Willow for female patients and Maple for male patients. Both wards have separate apartments that can accommodate a maximum of four patients. The two wards consisted of separate apartments built around a central secure courtyard. The wards were not physically separate units. At the time of our inspection, there were 18 patients at the hospital. Each patient had their own bedroom and each apartment had its own kitchen and living area.

The registered manager of Bradley Woodlands low secure hospital was also their controlled drugs accountable officer. The regulated activities at the hospital were the assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

An unannounced inspection of Bradley Woodlands low secure hospital took place on 9 August 2016 as part of CQC's comprehensive on-going inspection programme. At the time of this focused inspection, the rated report relating to the comprehensive inspection had not been published. However, subsequently it has. We rated the hospital overall as good. We rated the service requires improvement for Safe, and good for Effective, Caring, Responsive and Well-led.

Following the comprehensive inspection in August 2016, we told the provider that it must take the following actions to improve Bradley Woodlands:

• The provider must regularly check the emergency equipment so it remains suitable for use.

• The provider must ensure storage of drugs are at the correct temperature to keep medicines safe.

We also told the provider that it should take the following actions to improve:

• The provider should ensure enough qualified nurses on shift to complete the duties required.

• The provider should ensure the contracted primary care provider meets the needs of the service users in relation to the management of their physical health needs.

• The provider should ensure all staff treat patients with respect. For example, use respectful communication when interacting with patients.

• The provider should undertake an impact assessment prior to completing maintenance work, which may affect the patients in the hospital.

• The provider should ensure that clinical audits to monitor practice are comprehensive.

• The provider should ensure that all aspects of the patient complaints procedure is accessible to all.

• The provider should strive for section 17 leave to take place as originally planned with patients and relatives.

We issued the provider with one requirement notice, which covered breaches of Regulation 12 Health and Social Care Act (Regulated Activity) Regulations 2014 Safe care and treatment notice evidenced by 2(e) and 2(g).

An action plan from the hospital followed the publication the report of our August 2016 inspection, this showed the actions completed to resolve the issues found, and improvements made to maintain safe practice.

What people who use the service say

We spoke with six patients.

Patients told us they knew their named nurse, key worker, care staff and the hospital managers. Most said they had been involved in planning their care and supported by staff to understand their care plans. Patients described having their rights read and explained to them regularly.

Patients said most staff showed them respect and were polite. Patients liked the staff especially those who were kind and helpful. However, two patients told us that some staff looked for arguments and could be rude. One patient told us that staff seemed more stressed than they used to and there were higher sickness levels.

Summary of this inspection

The patients we spoke to all knew the advocate and felt able to see them if they wished to. Patients would complain to the advocate or one of the management team. Patients who had complained spoke of mixed responses; they told us that they usually received feedback, although this did not always happen. Patients seemed less sure about complaining about some staff. Two patients felt if they did the staff concerned, their friends or family working on site, might pick on them. We asked managers about these concerns; it was believed they related to incidents earlier in the year following which disciplinary action had been taken.

Patients liked having their own room with their own things in the apartment. Patients were aware what items they could or could not have with them in hospital. However, patients told us this was not always consistent between staff, which sometimes caused upset.

Three patients complained of being moved during the day to other apartments when the hospital had staff shortages. Whilst preferring this did not happen at all, two patients said if they needed to move they would prefer to be asked, rather than told.

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

Patients told us they had a choice of activities they liked to do. There was some frustration when these were changed or cancelled. Patients enjoyed going out of hospital into the community, however, this did not always happen due to staff shortages. Patients were concerned that cancellations seemed to have happened more recently.

Patients told us they were able to speak to relatives on the telephone. Staff supported relatives to visit; the systems around visits to patients appeared to work well.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following issues that need to improve:

- On days with only two qualified nurses on rota staff told us, they felt under pressure to complete their workload. On these occasions, spending time with patients and support workers was difficult to achieve.
- On days when cover for shifts could not be arranged staff felt unable to meet the needs of all patients. If leave was cancelled or patients moved to accommodate the needs of others, this could result in increased tension between patients.

However,

- Staffing levels were checked and reviewed by the management team and could be adjusted if patient needs fluctuated.
- Staff knew how to report incidents and the provider analysed and reviewed incidents at a range of meetings across the hospital.
- Compliance with the core mandatory training modules met the provider's 80% target.

Are services caring?

We found the following areas of good practice:

- Patients knew their named nurse, key worker, care staff, the hospital managers and the advocate and said they could talk to them.
- The staff and patient interaction we observed seemed familiar, responsive and respectful.
- Staff spoke to us about patients with care and compassion; they knew the content of care plans and could identify specific needs of individuals.

However,

- Patients told us whilst most staff were kind and spoke to them nicely, two patients said that at times some staff looked for arguments and could be rude to them.
- At times when staff felt under too much pressure, two staff acknowledged that they had observed staff becoming impatient or abrupt with patients.
- Staff identified that when care plans were not followed this created confusion for patients and difficulties for other staff.

Are services well-led?

We found the following areas of good practice:

Summary of this inspection

- Managers aimed to promote an open and transparent culture across the hospital, and staff knew they needed to be open with patients.
- The hospital used a range of ways including meetings, memos and newsletters to pass on key messages to staff.

However,

- Staff morale was described as low during day shifts, staff described feeling under pressure and not as valued as they might be.
- Low staff numbers were of high concern to both nurses and support staff, particularly when they had an impact on patient care.

Detailed findings from this inspection

Notes

We did not rate the hospital at this inspection.

Forensic inpatient/secure wards

Safe	
Caring	
Well-led	

Are forensic inpatient/secure wards safe?

Safe and clean environment

Not inspected

Safe staffing

The hospital establishment levels were: qualified nurses (whole time equivalent) 12 (made up of 14 nurses) and support workers 62 (whole time equivalent) which was made up of 66 support workers.

The registrations of the nurses employed were:

- Six registered nurse learning disabilities
- Six registered nurse mental health
- Two registered general nurses

The number of vacancies for qualified nurses (whole time equivalent) was one. Two additional nurses: one registered nurse learning disabilities the other registered nurse mental health, had been recruited and were awaiting their personal identification numbers from the nursing and midwifery council.

There was always at least one registered learning disability nurse or registered mental health nurse on each shift. Due to local difficulties in recruitment there were not enough registered learning disability nurses employed to have one on every shift. However, one of the two newly recruited nurses would be a registered nurse learning disabilities and the other one would be a registered nurse mental health.

The hospital used the providers staffing ladder to determine the staffing levels. This linked to the individual needs presented by each patient and their National Health Service England contract. The staffing levels were checked and reviewed by the lead nurse or deputy manager, across each 24 hour period with levels adjusted to meet the presenting needs, risks and activity commitments of the patients.

Staffing rotas were completed at least a month ahead to give time to fill any gaps in order of priority by existing staff; the hospital used bank staff first and then agency staff to try to fill remaining shifts. Additional staff were brought in to cover mandatory training. The deputy manager and lead nurse monitored the amount of overtime nurses and support workers worked to cover additional shifts, to ensure staff had time off.

The lead nurse who completed the shift planning worked to the recommendation from the providers staffing ladder. For 18 patients this indicated three nurses with 15 support workers daytime and two nurses with 13 support workers at night. There had been difficulties since early summer achieving this from the qualified staff employed as one nurse was off work with long-term sickness and another suspended. Agency nurses had provided some cover, and when it had not been possible to ensure three nurses during the day, the hospital would run with two qualified nurses on shift with an additional support worker brought so staffing numbers were 18 daytime and 15 at night. This meant that some shifts had below the minimum level of qualified nurses recommended by the staffing ladder tool. On the day we inspected, on shift during that day were two qualified nurses and 17 support workers. For the night shift we saw two qualified nurses and 13 support workers on duty.

There was a mismatch between the staffing levels using the providers staffing ladder and the information from the hospital manager. We heard from them that the establishment for the hospital required two nurses for each day and night shift with additional nurses on duty to cover the needs of the service. For example, when there were specific meetings, such as multidisciplinary team, care programme approach or a care and treatment review.

We completed a detailed review of staffing including rotas, which were both paper based and electronic. The planned rotas from 22 August to 25 September 2016 showed consistent levels of nurses and support workers over each 24-hour period. Whilst there was evidence that in planning there had been an aspiration to have three nurses on

daytime shifts, it was more frequent that two nurses, 15 support workers plus a floating member of staff throughout each day had been achieved, with two nurses and 13 support workers at night. In addition these rotas confirmed that an increase in staff occurred to accommodate a specific need for example, increased observation levels.

We reviewed the staffing allocation sheets completed each day by the nurse in charge for the week 6 to 12 October 2016. During the day, we saw two qualified nurses on each shift, with the exception of the multi-disciplinary team meeting day when three qualified nurses were on duty. Identified on the rota each day were two senior support workers who described their role as providing liaison between the apartments and the qualified nurses, recording notes onto the electronic system, supporting patients and covering in the apartments when needed. The support worker numbers showed as 16 on one day; 15 on four days, 14 on one day and 13 on the other day. This meant during the day the numbers of staff were over the minimum recommended however, the number of qualified staff on duty did not match the provider's tool. Each night we saw two qualified nurses on duty with 13 support staff on five nights and 12 support workers on the other two nights. On both occasions, 13 support workers had been on the rota but a staff member had gone sick at short notice and no cover had been found.

Staff perception at the time of the inspection was that whilst staffing numbers might work on paper there were not enough staff to meet patients' needs. For example, if plans had been made to go out into the community and this activity was cancelled, it had a negative effect on the mood of the patient. Whilst, managers told us where possible cancelled leave was rearranged, or was postponed rather than cancelled, staff managing situations on the day expressed concerns about the upset this caused to patients.

During inspection, we reviewed the allocation sheets across seven night and day shifts by looking at the actual staff on shift. On night shifts, we found two qualified nurses on each shift with 13 support workers on duty on five nights and 12 support workers on the other two nights. On day shifts, we found three qualified nurses on only one day, the other days having only two qualified nurses on duty. Every day shift had two senior support workers supporting patients and staff working between the apartments and the nursing office. The support workers allocated to the apartments varied: 13 on one day; 14 on two days; 15 on three days and 16 on one day.

Staff nurses' working day shifts felt under pressure, explaining that it was difficult to complete all their responsibilities effectively with only two on duty across a 12.5 hour shift. The impact of this was that one to one time for patients with their named nurse had not always happened. Nor had adequate time been available to offer effective supervision of support workers. Nurses also spoke of it not being possible to spend enough time in the apartments with support workers and patients.

However, over long days, most staff believed teamwork was positive, with staff pulling together for support, especially following an incident.

The length of day shifts was 12.5 hours and night shifts were 12 hours. Staff had two allocated break times of 20 minutes on each shift in accordance with the working time directives. Breaks were set within the shift for staff by the nurse in charge. Whilst breaks needed to be managed effectively to ensure safety in the hospital, staff were encouraged to take their breaks. The support workers we asked said they could and did take breaks away from the apartments. With only two nurses on duty, they found it more difficult to leave the ward area for a break, so, took time out either within the ward office, or briefly in the grounds carrying with them a radio and an alarm so they could return to the ward area quickly.

The number of shifts to cover sickness, absence or vacancies in the three-month period 1 July 2016 to the 30 September 2016 was 118. Of these staff overtime, bank or agency staff covered 44, leaving 74 shifts not covered, this was 3% of the 2856 shifts required to cover the hospital over 24 hours. Management told us that the shifts not filled were those with little prior notice for example, staff reporting sick when neither bank nor agency staff had been available.

A patient told us that staff seemed more stressed than they used to and sickness had increased. We asked for the figures and found that staff sickness rate in the 12-month period 1October 2015 to 30 September 2016 was 7% which was an increase from 1 August 2015 to 31 July 2016 when the sickness rate had been 4%. These figures did not include work related injury or long-term sickness.

Forensic inpatient/secure wards

Staff believed that unexpected absence leaving gaps in the rota, for example, sickness seemed to affect the day shifts more than shifts at night. Staff with experience of work across both shifts identified less demands, stress and pressure on the night shift.

A number of support workers felt the allocation of staff to apartments could be unfair with the staff nurse in charge of a shift showing favouritism to friends or relatives. We reviewed the sheets allocating staff to apartments and discussed this with the nurses in charge of each shift who made the allocations. We saw evidence of support workers in different apartments across a week and heard rationale that showed consideration both of the need to rotate support staff and their key working responsibilities to individual patients.

Staff turnover in the 12 month period 1October 2015 to 30 September 2016 for support workers was 21% and for nurses 21%. Exit interviews carried out with all staff, showed no common themes. Reasons given included: moving on for higher pay; retirement; personal circumstances; transfers within the organisation; further development/ nurse training and staff dismissal.

The activity coordinators and the occupational therapist facilitated the majority of internal activities with the assistance of support workers. Patients expressed some frustration when these were changed or cancelled. Patients were concerned that cancellations seemed to have happened more recently. We asked for the figures and no internal activities had been cancelled in the three month period 1 July 2016 to the 30 September 2016, however, 168 out of 538 (31%) section 17 leave were cancelled or postponed. This was an improvement on the three month period May to July 2016, when 36% of section 17 leave had been cancelled or postponed. Managers told us a considerable number were rearranged as soon as possible, so were postponed rather than cancelled and none of the complaints made in this time related to cancelled or postponed leave.

Resource issues recorded by the hospital for cancelling leave included: leave retracted for safety reasons where risk assessment indicated leave may not be safe either for the individual patient, hospital staffing needs; hospital transport repairs; poor weather conditions and staff needing to remain in the hospital to ensure safety.

Patients told us they particularly enjoyed going out of hospital into the community, however this did not always happen due to staff shortages. Three patients commented they had been really upset when their leave was cancelled because of lack of staff.

Patients disliked moving apartments to accommodate leave, appointments or meetings for their peers. For some patients, who were seen as more able to move around the hospital this happened to free the staff from their apartment to undertake other duties. The duration of these moves varied but could last a number of hours. Support workers also commented that it seemed unfair and disruptive to the care of the patients required to move. When we asked the registered manager about this practice, they felt it was a fair system as the patients asked to move for others would benefit from someone else moving to accommodate their needs.

The two activity coordinators and the occupational therapist facilitated the majority of internal activities with the assistance of support workers. Patients expressed some frustration when these were changed or cancelled. Patients were concerned that cancellations seemed to have happened more recently.

The consultant psychiatrist was on site four days a week, and could be contacted by phone if needed. An on-call rota provided telephone support over 24 hours by a team of psychiatrists employed across the provider's services. If a psychiatric emergency occurred the on-call psychiatrist would attend, how long this took would be dependent on the location of the psychiatrist on call. Annual leave was planned between the consultants and key events, for example, tribunals were not planned when the consultant known to the patient was away. Cover for leave or sickness, was either by a colleague from the Lighthouse team or in exceptional circumstances by a locum psychiatrist.

In a medical emergency, if the psychiatrist was on site they would attend, the hospital had a contract with a local general practitioner practice; staff had also used the 111 number for advice, dialled emergency services, or taken the patient to the accident and emergency department at a local NHS trust close by.

The hospital target for mandatory training was 80%. Excluding staff induction where compliance was 100%, staff compliance rates for mandatory training and updates at Bradley Woodlands was 86% overall.

This was made up of:

- Annual update 84%
- Safeguarding 84%
- Infection control 84%
- Fire safety 84%
- Intermediate life support (defibrillation) 84%
  Mental Health Act, Mental Capacity Act and deprivation of liberty safeguard training 84%
- Equality and diversity 84%
- Staff completed four-day stand-alone conflict management training, with a focus on de-escalation with update training annually 100%.

In addition, the hospital had ten certified first aiders.

Assessing and managing risk to patients and staff

Not inspected

Track record on safety

In the 12 months between 1 October 2015 to the 30 September 2016, the hospital reported six level four serious incidents. We reviewed the summary information from the initial 24 hour reports sent to NHS England and considered the hospital's processes following incidents.

The provider had a policy and procedure for serious untoward incidents with reference made to reporting incidents in other policies including the management of self-harm, management of aggression.

Where first aid had been required, this had been administered in a timely way, safeguarding referrals had been made when appropriate and in each case, the CQC was notified.

To reduce harm and make improvements within the service, senior management and the multidisciplinary team reviewed serious incidents at clinical governance, hospital planning and executive team meetings. Post-serious incident reviews were discussed and lessons learned considered, including how these lessons would be communicated to staff. This was usually through memos or staff meetings.

From the serious incidents we reviewed clear lessons learned had been identified and changes made within the hospital in response to these.

Reporting incidents and learning from when things go wrong

The staff we spoke to understood the need to report incidents and knew how to do so in the hospital systems. One staff member told us that whilst aggressive incidents were always reported, intolerance or verbal altercations between patients that might have an emotional impact and lead on to a bigger incident were rarely reported as an incident. Of the 227 incidents recorded between 1 July and 30 September the categories included physical assault; self-harm; verbal aggression; vandalism; attempted absconsion and theft. Verbal aggression made up 14% of these recordings, these were low-level and primarily towards staff.

Electronic and paper systems ran alongside each other at the hospital. Staff used a patient's daily care notes and a paper form to record incidents. The nurse in charge had responsibility to ensure the paper information was transferred onto the electronic incident recording system; this was achieved with the support of a hospital administrator. Whilst this was not the purpose of the separate systems, the double reporting of incidents allowed cross-referencing during any incident investigation, offering additional transparency. There was a separate reporting book for accidents for example slips, trips and falls.

Specific incidents were discussed in the weekday morning meeting by the multidisciplinary team. This meeting promoted communication between the wards, multidisciplinary team and senior managers. The meeting covered staffing levels, incidents, and queries from patients brought by managers. Each day team members unable to attend had minutes of the meeting emailed to them.

Reviews of incidents relating to individual patients took place within multidisciplinary team meetings, care programme approach meetings and care and treatment reviews. Whilst nurses felt part of this, support workers did not. Incident reports from the electronic system reviewed within meetings showed trends, for example, recurrence of incidents at a particular time of day, with ease. Incidents reviewed at patient meetings informed some changes in care planning.

Other reviewing processes the hospital used included incident analysis meetings, serious incident reviews, clinical governance, health and safety meetings, post

serious incident reviews, hospital planning meetings and executive team meetings. At these meetings, monthly electronic data showed analysis by type, apartment, restraint, weekday and overall trends. Minutes from these meetings were available to staff.

We reviewed minutes of clinical governance and hospital planning meetings and saw the recording of incidents reviewed. A member of the senior management team closed incidents on the electronic system following a completed review. We saw a delay in closing some of the incidents with completed reviews. Following incident investigation, we saw specific update training identified communicated to staff through meetings. For individual staff members disciplinary action had been taken following incident reviews.

Following serious incidents, we saw evidence of individual staff debriefs. The purpose of which was to enable staff to express feelings they have regarding an incident. Within this low secure environment team de-briefs were not held, this meant that shared exploration and understanding of what had happened and how staff were feeling did not take place. However, support was available through planned and ad hoc supervision from colleagues, and members of the management team. This support explored what might be learned from what had happened and led to staff receiving individual feedback following specific incidents.

Duty of Candour

Duty of candour is a legal duty on a hospital to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. It aims to help patients receive accurate, truthful information from health providers. All staff knew the need to be open with patients and explain to them if things go wrong. Of the ten staff that discussed this, five were clear that it would always happen and that a qualified staff member or a manager would do this. Two staff felt it would depend on the individual patient as it might cause additional difficulty for them if an explanation was given for something they may have forgotten or not been aware of but believed a relative would be informed. Three staff were unsure if a patient or their relative would be told at all. However, when we reviewed incidents we saw documentation evidencing a patient told about an information governance breach, with an explanation and formal apology given.

Are forensic inpatient/secure wards caring?

Kindness, dignity, respect and support

During inspection, we spoke to six patients, observed an activity group, and spent time during the day and the evening in the ward environment where we spoke to four nurses and 17 support workers.

The patients we spoke to told us staff were polite. Most spoke nicely to them and treated them with respect. Patients liked the staff especially those who were kind and helpful. Most patients said they could talk to staff. However, two patients told us that some staff looked for arguments and could be rude. The staff and patient interactions we saw seemed both familiar and comfortable. In the activity session, we observed staff attitudes and behaviours when interacting with patients were responsive and respectful.

Patients told us they knew their named nurse, key worker, care staff and the hospital managers. The patients we spoke to all knew the advocate and felt able to see them if they wished to. Most said they had been involved in planning their care and supported by staff to understand this. Three patients were able to show us their care plans. Patients told us staff informed them of their rights under section 132 of the Mental Health Act and explained these regularly to them.

The support staff we spoke to and observed understood the individual needs of the patients in their apartment. Staff knew the content of care plans and could identify the specific needs of individuals. The clear message from both managers and qualified staff was that individual care plans needed to be followed. To ensure staff had access to care plans, copies were available in each apartment, support staff were aware of these and the expectation that they would check for any changes or updates when working with individuals in the apartments. Two support staff identified that when care plans were not followed this created confusion for patients and difficulties for other staff.

Staff spoke to us about patients with care and compassion. However, a support worker told us that at times when staff felt under too much pressure, they could become

impatient or abrupt with patients. Reports of inappropriate staff patient interaction had been reported to management, were investigated and in some cases this had resulted in disciplinary action.

Patients we spoke to who had been restrained said this had been done with care and only after other things to calm them down had not worked. We heard from patients about special care plans which described how best to keep them safe when distressed. For one patient this included use of the sensory room. The plans we saw were individual positive behavioural support plans.

Patients told us they could complain to the advocate or one of the managers. The deputy manager or lead nurse did a daily walk round during which they listened to any concerns patients had. Patients who had complained spoke of mixed responses; usually they received feedback, though not always. Two patients seemed less sure about complaining about individual staff, feeling if they did the staff concerned or, their friends or relatives working on site, might pick them on.

Staff told us they would pass on any complaints made by a patient to a manager on site, or the senior nurse on shift. Complaints and concerns raised by patients were discussed at the multidisciplinary morning meeting where any follow-up actions were identified and recorded in the minutes. The hospital manager spoke with patients informally following a verbal complaint, giving feedback to the individual concerned.

Following a more formal complaint, patients received feedback on the outcome of investigation of complaints by both face-to-face meetings and letter. Copies of letters written in response to complaints were formal and it was unclear how accessible this format was to the patients in receipt.

The main complaints patients voiced to the inspection team were their leave or activities being cancelled and having to move from their own apartment to another during the day. When we raised this with the hospital manager, we were told that apartment moves for those patients who were able to move did happen to free up staff to escort other patients on leave, or to attend appointments. We asked how often this occurred however, it was not clear that the frequency of those patients able to move was monitored.

The involvement of people in the care they receive

Not inspected

Are forensic inpatient/secure wards well-led?

Vision and values

Not inspected

Good governance

Not inspected

Leadership, morale and staff engagement

The most recent staff survey was completed in March 2015 so did not provide in date information to inform this inspection. However, themes from the supervision of staff collated by managers from April to June 2016 showed:

- Forty nine staff members stated good job satisfaction; ten some job satisfaction and one no job satisfaction.
- Thirty three staff members felt their work was recognised; five felt some recognition; and one no recognition.
- Fifty three staff members felt supported; two felt supported sometimes and two felt unsupported.

From our interviews with staff, they told us that they felt able to make suggestions about the service informally through ad hoc conversations with managers and colleagues, discussion within individual supervision and more formally at staff meetings when able to attend. The hospital manager told us practitioners and patients had the opportunity every week to input into service development at the patient and staff involvement forum.

In addition to communication with individuals through supervision, emails and letters, the hospital used planned staff meetings and newsletters to pass on key messages to staff. Staff recognised staff meetings were available. However, more than half the staff we spoke to did not feel these were accessible due to work or personal commitments. These staff relied on verbal feedback from colleagues who had attended and the minutes following staff meetings for information. We reviewed the August 2016 newsletter, which included 16 items about events including training, expectations of staff, reminders, up-dates on processes, policy and staffing as well as thanks to staff.

Forensic inpatient/secure wards

Staff sickness in the 12 month period 1 October 2015 to 30 September 2016 was 7% however, this did not include work related injury or long-term sickness.

Two staff had reported feeling bullied in the past year. Following these allegations, full investigations took place.

Staff were aware of the organisations whistleblowing policy, and knew they could contact external organisations if they felt unable to go directly to managers within the hospital. Whilst most staff we asked said they would go to managers to raise concerns, three were worried that if they did so they might be victimised by friends or relatives of particular staff members working on site. Two patients had also expressed this concern.

Within the staff group, there were individuals involved in personal relationships with each other and managers were aware this might cause reluctance to report. However, they spoke of an open door policy and staff approaching them regularly to raise concerns. We saw evidence of investigations carried out following concerns raised by staff, some of which had resulted in disciplinary hearings and dismissals.

Staff recognised they were working within an environment that was demanding on a daily basis and raised concerns about the support available to those working long shifts on the wards. All staff spoke of trying to support each other, particularly following an incident. Outside of core hours, supporting staff in the apartments became the responsibility of the nurses on duty. Whilst fully aware of this, nurses told us the time available to support the support staff would depend on how many other priorities they had on a particular shift. At times, they recognised this support became the role of the senior support workers rather than themselves, which left a gap in clinical oversight across the apartments.

Both nursing and support staff on the day shifts commented on staff morale being low. Specific issues identified were low staff numbers, particularly when staff had gone off sick at short notice and no replacement had been found. Staff feared the hospital might lose more staff due to low morale and that would put additional pressure on those who remained. Staff felt morale was also affected when patients became upset about cancelled leave or having to move apartments to accommodate the needs of other patients. The frequency that this happened had an impact on plans previously made with patients, leaving key workers feeling less effective than they might.

Managers were aware of low staff morale during the day. Whilst working hard to ensure sufficient staff numbers on shifts and take action in relation to specific concerns raised, they had found it difficult to change the culture. The support workers in the apartments continued to feel separate from the qualified nurses and multidisciplinary team members working with the patients.

The ten staff we spoke to on the night shift believed morale on nights was more positive than in the daytime. Staff felt they had the time to provide individualised care to patients. Qualified nurses spent time with patients and felt able to support staff directly. The environment was described as calmer with fewer demands for example, phone calls requiring an immediate response than in the daytime. The team were clear about what they needed to do and we saw support between the team to achieve this. Night staff had felt particularly supported when the deputy manager came onto shift for meetings earlier in the year. Whilst this had not happened over the summer they were hopeful this contact might happen again in future.

Staff believed the multidisciplinary team worked together to support patient recovery. However, support workers who spent most time with the patients felt their voice was seldom heard in this forum. They understood it would be difficult to be present at all meetings, but believed that if staffing numbers were greater they could both support the patient's they were key worker for and offer additional input to the wider team.

Staff saw supervision as supportive, providing there was time within it to ask about their concerns. At busy times, supervision was described as being rushed and a bit of a tick box exercise. Staff also identified training as an environment where staff could think as a team, sharing experiences and receiving both support and challenge safely.

Managers aimed to promote an open and transparent culture across the hospital. From interviews and documents seen during inspection, it was clear staff understood their responsibilities to report poor practice.

Staff received training and were confident about how to raise a safeguarding concern. The local safeguarding

adults' team received a monthly low level safeguarding report from the hospital. We reviewed the report for September 2016 and found 18 incidents between patients, eleven physical; six emotional and one verbal. In addition to the incidents within the monthly report, the deputy manager would report any more specific concerns immediately on an individual basis to the external safeguarding team and as a notification to the care quality commission.

All staff knew the need to be open with patients and explain to them if things go wrong. However, of the ten staff that discussed this, three staff were unsure if a patient or their relative would always be told. Managers were confident that when relevant, relatives had been alerted to issues reported. We saw evidence of occasions this had happened.

Commitment to quality improvement and innovation

Not inspected

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are enough suitably qualified, competent and skilled staff on duty to meet individual patient needs, including planned activities and access to the community, with enough qualified nurses on shift to complete the professional oversight required.

Action the provider SHOULD take to improve

- The provider should ensure all staff treat patients respectfully at all times.
- The provider should ensure patients are moved about to accommodate others only in exceptional circumstances.
- The provider should strive for section 17 leave to take place as originally planned.
- The provider should work with staff to improve morale across the hospital.

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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Shifts with only two qualified nurses on duty during the day were frequent; this was low in a hospital environment with a mix of patients with complex needs. Qualified staff numbers were increased on days when meetings took place; however, this did not allow regular oversight by qualified staff of the care in the apartments. Staff numbers showed consistency of 17 during the day and 15 at night however, patients were moved into others apartments to accommodate the needs of their peers to have leave or attend appointments. This meant there were not sufficient numbers of suitably qualified, skilled staff on duty to meet all the needs of the individual patients. This was a breach of regulation 18 (1)