Nottinghamshire Healthcare NHS Foundation Trust

High secure hospitals

Inspection report

Duncan Macmillan House
Porchester Road
Nottingham
NG3 6AA
Tel: 01159691300
www.nottinghamshirehealthcare.nhs.uk

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inadequate**

Our findings

High secure hospitals

Inadequate 

We carried out this unannounced focused inspection of Rampton High Secure Hospital because at our last inspection in September 2022, we rated the hospital overall as requires improvement. Due to our findings, we served the trust with a Section 29A warning notice, informing the trust they were required to make significant improvements. This inspection was carried out to check if changes and improvements had been made.

Following this inspection, we have issued further enforcement action for the trust to make significant improvement in the areas not complied with since we issued the warning notice at our last inspection in September 2022. We have imposed conditions onto their registration and issued these in September 2023.

The provider took actions following the inspection to improve and address the concerns we raised.

We have rated safe, effective and well led following this inspection.

We found:

- Managers had not ensured that wards had enough nurses to keep patients safe and wards had high vacancy rates. Activity and therapy staff were regularly redeployed to wards to support nursing staff, which impacted on patients' ability to access recreational and therapeutic activities. Staff did not always minimise the use of restrictive practices. Staff regularly confined patients to their bedrooms during the day to maintain safety on the wards. This was not carried out in line with trust policy, which only permitted confinement at nighttime. Staffing levels was highlighted as a concern at our last inspection.
- Managers did not always ensure that staff received regular formal supervision.
- The hospital did not ensure that effective systems and processes were in place to correctly authorise medicines in line with the Mental Health Act.
- Staff had not ensured accurate titration (adjusting the balance) of some medicines over a specific timeframe had been calculated. This meant that patients were exposed to the risk of having higher doses of medicine than required.
- Staff did not always observe patients fully when in seclusion.
- De-escalation techniques were not always used by staff as a first resort to manage patients who became distressed. We found episodes of seclusion that were not proportionate to the risk posed by patients.
- Managers did not ensure that there were effective systems and processes in place to monitor quality of care when staff were supporting patients in distress.
- Staff used restrictive practices such as early confinement and late unlocking routinely and this had become usual routine practice authorised by managers to manage risk. Managers had not taken timely steps to prevent this becoming a normal culture within the hospital.
- The hospital did not have enough staff trained in British Sign Language to meet the needs of deaf patients. Staff on the ward for deaf people, communicated with each other verbally, and did not use BSL. This meant, deaf patients

Our findings

could not be included in the everyday sounds and noises of the ward and were excluded from social communication that takes place between people in communal areas of the ward. This also excluded deaf patients from joining conversations with staff, meant they were not able to understand what was happening around them and what was happening on the ward.

However:

- Staff had improved how they had managed patients' access to risk items on the wards.
- Staff had improved how they identified and recorded patients' physical healthcare needs on the wards.
- Seclusion care plans for patients were completed in line with the trust's restrictive practice policy since our previous inspection.
- Staff improved how they monitored patients' physical health after rapid tranquilisation was used.
- The hospital had improved mail and telephone monitoring arrangements, in line with the Mental Health Act.

How we carried out the inspection

During the inspection we:

- spoke with 23 patients
- interviewed 24 staff members
- reviewed 18 patient care plans
- reviewed 34 patient medical records
- reviewed 7 telephone and mail recording reviews
- reviewed 3 incidents on CCTV
- reviewed 2 seclusion records
- reviewed 2 long term seclusion records
- visited 10 wards.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the hospital say

We spoke with people in the learning disabilities services who told us they sometimes get locked in their room from dinner time until the next morning. They told us that they don't like being locked in their rooms. People told us that there were enough staff when in seclusion but not enough when they come out. People told us that the Southwell Centre is closed so there were no activities because staffing from the Centre were needed on the wards. Patients would like to do more activities. People told us that when in early confinement they can't make phone calls with family or have contact with other patients. People told us that when in confinement the rooms can be really hot and uncomfortable.

We spoke with patients in the women's service who told us they were offered activities, but it depended on staffing levels. People told us the hospital was short staffed and sometimes felt unsafe. People told us staff were kind.

Our findings

We spoke with patients in the deaf services who told us they wanted to do more but there were not enough staff. People told us that there were staff trained in British Sign Language (BSL), but it was basic. This meant deaf patients had to adjust how they spoke with staff so they were understood. People told us that there just wasn't enough staff.

We spoke with patients on the mental health wards who told us staff can't form relationships with patients because they don't stay at Rampton long enough. A patient told us that they had more freedom in prison due to the confinements in place at Rampton. People told us that they are not able to do much on these wards due to lack of staff

Is the service safe?

Inadequate  

Our rating of safe stayed the same. We rated it as inadequate.

Safe staffing

The hospital did not always have enough nursing and medical staff to keep patients safe. Staff regularly had to confine patients in their bedrooms during the daytime and limit their access to activities and leave due to low staffing levels. This was identified at our last inspection in September 2022, and we issued the hospital with a warning notice to make significant improvements. At this inspection, we found these improvements had not been made. Further enforcement action has taken place due to this.

Nursing staff

The hospital did not always have enough nursing and support staff to keep patients safe. At this inspection, we found that managers had not ensured that wards had enough nurses and care staff and that wards had high vacancy rates. Activity and therapy staff were regularly redeployed to wards, which impacted on patients' ability to access recreational and therapeutic activities. This was identified at our last inspection in September 2022.

Site managers attended a daily demand and capacity meeting to look at staffing levels across the hospital. They regularly reviewed staffing throughout the day and ensured that the highest risk wards had enough staff to maintain patient safety. The hospital had a staffing contingency plan in place which outlined the actions to be taken if staffing shortages exceeded 30% on wards. Actions included redeploying staff, including therapy and education staff, to wards and using daytime confinement on wards. This meant patients were restricted to their bedrooms to maintain safety.

Staff used strategies such as early confinement and late unlocking to manage patient risk. During the inspection on 1 July 2023, the whole hospital site was under level 4 in the hospital's contingency staffing plan. This meant that there was between 40% to 49% staffing deficit. We were told that this was planned at a management meeting about staffing, 10 days before the 1 July 2023, and that senior managers knew staffing levels were going to be at this level. We were informed of the decision to keep 4 wards under confinement from 8.40pm on the 30 June 2023 until 3pm on 1 July 2023 as this would release staff to support other wards.

We were told on 1 July 2023 that 10 wards were planned to enter early confinement, which meant that patients would be locked into their bedspaces earlier than expected. Early confinement meant staff could be released from one ward to support the needs of another when staffing levels were low.

Our findings

We found during the inspection that staff recorded when staffing levels fell below 70% under the hospital's serious incident protocol. We reviewed the serious incident data from February 2023 to June 2023 and found there were 58 times when patient rooms were unlocked late from nighttime confinement (the usual time for unlocking of bedrooms after nighttime confinement was 8am).

On 6 occasions, wards were placed in confinement during the day and on 101 occasions wards were placed in early confinement, ahead of the usual nighttime confinement (this meant patients were locked into their bed spaces before the scheduled time of 8.45pm). Cheltenham ward (part of the learning disability services) was placed in early confinement at 2.30pm which meant that patients were confined for 17 hours and 30 minutes. This meant low staffing levels impacted on patient care.

Patient care was impacted by the strategies used to keep patients safe due to low staffing levels. We found that when patients were confined to their rooms, either due to early confinement or late unlocking, they went without access to fresh air. They also received food, drinks and medicine through their door hatches. There was no access to telephone calls to be in touch with family or friends, no activities or social interaction. Patients told us that confinement was impacting on them, but they understood why it was happening. Patients told us that it was becoming "normal" for confinement to happen and to have activities to be cancelled.

Confinement exposed patients to an increased risk of harm. We reviewed incident data and found that there were 2 incidents that occurred during episodes of early confinement due to low staffing levels that resulted in harm to patients. Patient care notes we reviewed on Aintree ward, recorded that a patient had self-harmed with glass from their watch. They had broken the watch in their room on the 3 June 2023 due to early confinement of the ward due to low staffing levels as this had made them upset by the decision. The early confinement was recorded 'as per site manager instruction'. In addition, when speaking to a patient on Newmarket ward we were informed of an incident that occurred on 24 June 2023 where the patient had self-harmed with a Compact Disc after early confinement was put in place due to low staffing levels, again this was as a reaction to being confined in their room for a length of time. We saw wounds to the patient's arm following self-harm.

Some staff told us they felt unsafe when staffing levels were low. It resulted in missed breaks, not being able to use the toilet facilities and being unable to drink and eat during shifts.

Therapy and education staff told us they felt frustrated when they had to cancel therapeutic activities due to low staffing numbers.

When staffing levels were low, managers redeployed therapy and education staff to general ward areas. We reviewed data that showed from February 2023 to June 2023 there had been 473 occasions where redeployment occurred which resulted in planned activities for patients being cancelled.

At the time of the inspection, the hospital had high vacancy rates which impacted on staffing levels. The trust was working to recruit both nurses and non-nursing staff. The hospital had action plans in place and the hospital had recruited a head of people role that focussed on the staffing issue. Recruitment events had taken place which resulted in a planned onboarding of successful candidates. The hospital shared how the new starters would impact positively with the current vacancy concern at the time of our inspection.

Levels of sickness were high at the time of our inspection. The trust had a sickness target of 4%. We saw data that showed sickness levels at the hospital as 8.1% in June 2023.

Our findings

Mandatory training

During our last inspection in September 2022, we identified that not all staff had completed hospital life support training. We reviewed training data during this inspection and found that this had improved. We found that there was a completion rate of 87% out of 947 staff members who required the training.

Assessing and managing risk to patients and staff

Staff did not always follow best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they did not always use restraint and seclusion only after attempts at de-escalation had failed.

Management of patient risk

Staff knew the risks for each patient and acted to prevent or reduce risks. During our last inspection we found that the hospital did not always document when they had carried out patient observations in line with patients' identified needs. At this inspection, we found this had improved, and we found no gaps in the observation documents that we reviewed. However, staff and managers told us they felt frustrated with the potential delay of uploading the records due to internet issues with the devices that staff used. Senior managers had sent out communications to staff explaining how to use the devices effectively which would end the delay of uploading.

Use of restrictive interventions

Levels of restrictive interventions were high and were often used to manage risk when staffing levels were low. We have described how early confinement and late unlocking was used at the hospital, in the report above.

Staff did not always make every attempt to avoid using restraint by using de-escalation techniques. Staff used seclusion but did not always ensure patients were kept safe when in seclusion. During the inspection we were informed that a patient in the national deaf service had been placed into seclusion and during the seclusion period and had sustained an injury to themselves. We reviewed the incident and the corresponding closed-circuit television (CCTV) footage and found the incident form filled out by staff did not correspond with the incident and accurately reflect what was seen on CCTV. During our review of the incident, we found that the preferred communication needs of the patient was not used, and restraint techniques used did not follow best practice. There was no evidence that de-escalation techniques were used. We saw that when the patient was taken into the seclusion room, the staff involved in the restraint placed them in prone position (lying face down on their stomach) on the bed. There was no attempt to sit the patient up which is the best practice in this situation (following going to the bed in prone, every attempt should be made to turn the patient or change the position). This action exposed the patient to potential harm. We informed senior managers of our findings, who told us they would investigate the incident. We have not been provided with an update to this investigation.

Also, managers informed us that they had been made aware of an incident where restraint was inappropriately used with a patient in the learning disability service. We reviewed the CCTV and saw the use of restraint was inappropriate. We saw on the footage that the patient was sat down in a corridor and staff surrounded them. The nurse in charge approached the patient, spoke to the patient then turned and gave an order to restrain whilst walking away from the incident. No de-escalation techniques were used by staff. We spoke with the patient who told us that their shoulders and arm were painful due to the restraint used. Managers told us this incident would be investigated, that senior staff had already reviewed the CCTV and had concerns about the restraint used.

At the last inspection we found concerns about the lack of review of CCTV at the hospital. We found at this inspection that managers reviewed CCTV after every serious incident. Managers sent reports of their review for senior management to review.

Our findings

We reviewed seclusion data on Coral ward of a further patient who required support in their communication needs. This patient required staff who were trained in British Sign Language (BSL) and also required an interpreter. When reviewing the seclusion data, we found that between 1 February 2023 and 10 July 2023 the patient had been secluded 46 times, 36 times of which were after the registered BSL interpreters had finished their shifts. Within the 46 times of seclusion, we found 5 occasions where the patient had been secluded, seclusion records completed by staff stated that the patient was secluded due to being disruptive to other patients by banging and shouting upon night time confinement. During the inspection we reviewed CCTV of the most recent seclusion period for this patient. We saw that the patient was confined to their bed space after night time confinement period. We saw the patient banging on the window of their bedspace and staff who regularly went to the window, did not use sign language to communicate with the patient. Within an hour the patient was then escorted in holds to the seclusion room where they spent the rest of the night until 10.25am the next morning in seclusion.

Staff followed NICE guidance when using rapid tranquilisation. We reviewed rapid tranquilisation use on all wards in the learning disability services and found that staff followed NICE guidelines. We saw that staff carried out physical health monitoring following the use of rapid tranquilisation. This was identified at our last inspection in September 2022, and we issued the hospital with a warning notice to make significant improvements. At this inspection, we found these improvements had now been made.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We found concerns about how staff did not follow the hospital's procedure for seclusion at our last inspection. At this inspection, we reviewed seclusions plans of 3 patients who were recently in seclusion. We found no concerns with the records and saw that medical reviews took place and were recorded correctly.

However, when reviewing a seclusion incident discussed above, we saw that the staff member allocated to observe the patient whilst in seclusion had no line of sight and it appeared on CCTV footage that they had placed themselves in a position where they could not see the patient. This was for 20 minutes when the patient first entered the seclusion room. During that time the patient had taken the mattress off the bed and taken it into the bathroom area which then became a blind spot. This meant that observations of this patient were not completed following the hospital's policy.

Medicines management

Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. At our inspection in September 2022, we found gaps in the monitoring of patients' physical health after rapid tranquilisation. At this inspection, we reviewed 50 patient medical records and found no concerns with documentation and saw that staff carried out physical health checks post rapid tranquilisation. We saw that rapid tranquilisation was rarely used.

The hospital had a quality lead in place, and they told us that the hospital had introduced flash cards around the use of rapid tranquilisation which explained the process along with what action was required following rapid tranquilisation.

Staff had not ensured that titration (adjusting the balance, whether any medication needs to be increased or reduced) of some medicines had not been carried out effectively. When reviewing medical records on the learning disability service we found 2 patient records where the patient's antipsychotic medication needed to be reduced within two months making sure it was within the British National Formulary (BNF) guidelines. We found that there were no plans in place to reduce this in line with guidance. This meant that patients may be exposed to the risk of having continued high doses of medicine. This was brought to the attention of the nurses at the time of the inspection.

Our findings

Reporting incidents and learning from when things go wrong

The hospital managed patient safety incidents well. Staff recognised incidents but did not always report them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider hospital. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff did not always report incidents in line with trust policy. When speaking with a patient on the National Deaf Service ward, they told us they had recently been secluded but did not understand why. They said staff had told them it was because they had been aggressive on the ward. They had injured themselves during seclusion due to frustration of the situation. We reviewed the incident form and the corresponding CCTV of the incident. The incident form stated that the patient had become aggressive and was spitting on the floor. When we reviewed the CCTV, we saw that this was not the case. The patient was sat in the communal lounge, and we noted they were looking over at staff. We saw staff had not used sign language to deescalate the incident or when the patient was placed into restraint. The patient was seen to be in a walking hold with two staff members which restricted the patient's arm and hand movements, limiting their ability to communicate using signing. The patient was seen to go towards the bed areas of the ward as they told us they thought they were being taken to their room to calm down. Staff changed direction away from the bed area and escorted them into the seclusion room.

We brought to this to the attention of hospital management and at the time of writing, we have not received an update.

Is the service effective?

Inadequate ↓

Our rating of effective went down. We rated it as inadequate.

Best practice in treatment and care

Staff did not always ensure that patients had good access to physical healthcare and supported them to live healthier lives.

Staff identified patients' physical health needs and recorded them in their care plans. We found that in our review of patients' physical care plans, the hospital had improved since our last inspection in September 2022. At this inspection, we found no gaps in physical health needs. During our inspection, we saw the physical health team on wards that we visited assessing patients and offering support to patients. However, we found one record where a patient had not received a review of their skin integrity. The patient had told us they had a sore bottom due to their incontinence wear. We informed ward managers, and it was dealt with immediately. The physical health care team came to assess the patient and immediately implemented regular skin integrity checks.

We found one occasion when a patient had a physical health examination on their genital area but without the aid of BSL trained staff or an interpreter. The records we reviewed said the patient thought they were having a health check on their head injury and didn't know that it was for something different. This meant that the patient had no one to support them in the communication between them and the health staff.

Our findings

Skilled staff to deliver care

Managers did not always support staff with appraisals and opportunities to update and further develop their skills. Staff did not receive regular supervision.

Managers did not always support non-medical staff through regular, constructive clinical supervision of their work. At our last inspection in September 2022, we found supervision levels for all wards were at 59% between February and July 2022. At this inspection, we found that the supervision levels were at 60% for all wards between February 2023 and June 2023 and this was directly related to low staffing levels. The staff we spoke with said they do feel supported and have had informal supervisions and management. They said it had been explained to them that supervisions haven't been as regular due to low staff levels.

Managers had not ensured staff had the right skills and qualifications to meet the needs of the patients in their care. During our last inspection in September 2022, we found that there were not enough staff trained in British Sign Language on the National Deaf Service (Grampian ward) and that there were not enough interpreters to support the patients who required them.

At this inspection, the hospital had provided more interpreters who were available for the patients and had employed some staff that were deaf. However, they were still not available during the evenings and at the weekend. We found examples where incidents had occurred due to the lack of staff trained in BSL and no interpreter being available due to the time of day. For example, the incident detailed above regarding the physical health check of a deaf patient where they thought it was for their head but it was actually to review their genital area was conducted on a Sunday afternoon where there was no signer or interpreter available. We completed a review of a patient's care plan which stated that being able to communicate with others including interpreters and BSL trained staff, would be able to de-escalate the patient if they became agitated or distressed. The care plan stated that frustration and distress occurred when they are not able to be understood by staff and peers when there were no BSL staff and interpreters available. This resulted in the patient displaying anger.

We reviewed the British Sign Language (BSL) training figures for staff working on Grampian ward. This showed that out of 25 staff ,16 were trained in BSL level 1 and 14 were trained in level 2. Only 2 staff were trained in BSL level 3. This meant that the preferred communication methods for deaf people within the hospital could not be met effectively. Patients told us that due to the level of BSL used by staff they needed to alter how they spoke as staff weren't able to converse in full conversations. They told us that they had to simplify what they were saying so that staff could understand them. They told us that this can be frustrating. The level of BSL trained staff was not enough to allow 'normalised' conversation between patients and staff. We were not assured that due to this that the patients had access to staff who would be able to discuss complex emotional issues with them. Patients were required to adapt their communication so staff could understand their needs. This meant that preferred communication methods were disregarded, and this amounted to discrimination for those who had protected characteristics.

We observed during our time on Grampian ward that staff were not using BSL all of the time in their communication to patients and staff. Staff used spoken word to communicate with each other, which prevented patients' involvement in social communication taking place. In other wards of the hospital, both patients and staff would be able to hear the environment, background noise and social communication, staff chatting to patients and patients talking to each other. This culture was not present on Grampian ward. We did not observe staff support or including deaf patients in the milieu (background environment) of the ward.

Our findings

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them. However, staff did not follow the Mental Health Act Code of Practice to ensure medication records reflected the correct consent to treatment record.

At out last inspection in September 2022, we were concerned that the hospital did not ensure that effective systems and processes were in place to correctly authorise medicines in line with the Mental Health Act 1983. During this inspection we reviewed 44 medication records which included reviewing the certificates of consent to treatment certificates (T2) and certificates of second opinion (T3). We found treatment authorisation certificates did not match the corresponding medicine administration record (MAR).

On Aintree ward (part of the learning disability services), we found 1 medication administration record (MAR) did not reflect the details contained in the 'Certificate of Consent to treatment' (T2) record. We found a patient had been prescribed a depot injection that had been omitted from the T2 certificate. On this ward we also found 1 MAR that did not reflect the details contained in the 'Certificate of second opinion' (T3) record. Another record for a patient had not accurately documented the correct titration of antipsychotic medication. On Cheltenham ward (part of the learning disability services), we found 1 MAR that did not reflect the details contained in the 'Certificate of second opinion' (T3) record. The record showed that it had not been accurately documented with the correct information of the antipsychotic medication.

We were not assured that the hospital had made any improvements on this issue since the last time we inspected.

At the last inspection in September 2022, we found concerns with how staff monitored mail and telephone systems. At this inspection, we found the hospital had improved their systems and processes to ensure that staff regularly reviewed the mail and telephone monitoring arrangements of patients who were subjected to this, in line with section 134 of the Mental Health Act 1983.

Is the service responsive?

Inspected but not rated

This key question was inspected but not rated. Our rating of responsive stayed the same. We rated it as requires improvement.

Meeting the needs of all people who use the hospital

The hospital did not always meet the needs of all patients – including those with a protected characteristic. Staff did not always support patients with their preferred communication method.

Managers did not always make sure staff and patients could get help from interpreters or signers when needed. As detailed above we found the hospital did not have interpreters available 24/7 and at weekends. This impacted patient care. We found several incidents where BSL had been used it may have prevented an escalation of situations described above or had prevented an incident of miscommunication about a physical health examination.

Our findings

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team and hospital level and that performance and risk were not always managed well.

During this inspection we were not assured that hospital managers had made enough significant improvements since our last inspection in September 2022 and the actions from the enforcement action we took were not all complied with.

There were not enough staff to manage patient safety and risk. Contingencies such as early confinement and late unlocking had impacted on safe care. We remain concerned that low staffing levels, high levels of sickness and vacancies resulted in the used of restrictive practices. and the continued use of confining patients to their rooms as a result of unsafe staffing levels.

Since our last inspection in 2022, we have continued concerns over the lack of sufficiently trained, experienced and competent staff trained in BSL to support the needs of patients who require it.

There were not effective systems and processes in place to ensure the quality of care was monitored in order to identify how care could be improved. For example, incident records did not reflect the actions of staff during an incident that had been reviewed on CCTV. We found titration of some medicines had not been accurately calculated. We found issues with the use of the Mental Health Act Code of Practice to authorise and document consent to medication. Systems and processes were not in place to ensure checks of this documentation highlighted errors, and as a result, errors were not corrected.

Managers acted quickly when we raised concerns with them over issues with the use of restrictive practices and physical health monitoring. However, we have not received any response to the concerns raised.

Managers told us they acted on recruitment and since our inspection have acknowledged how the risk that low staffing numbers had impacted on patient care. However, this was raised at out last inspection in September 2022, and the pace of change to make significant improvement has been slow.

Managers had made some improvements to provide supervision to staff as staff we spoke to us felt supported but on an informal basis. The culture of having informal supervisions was now the normal for staff and although they felt supported the formalisation of supervisions was behind due to staffing issues this meant the compliance rate of staff receiving supervisions continued to be low.

Systems and processes to monitor CCTV had improved since our concerns at the last inspection in September 2022, and mangers had ensured staff recorded physical health observations following the use of rapid tranquilisation.

Culture

Our findings

We were concerned that the issues we identified at this inspection, had not been recognised by leaders and had resulted in staff accepting their actions had become routine.

We saw that hearing staff on the ward for deaf people, communicated with each other verbally, and did not use BSL. This meant, deaf patients could not be included in the everyday sounds and noises of the ward and be excluded from social communication that takes place between people in communal areas of the ward. This meant it excludes deaf patients from joining conversations with staff, not being able to understand what is happening around them and what was happening on the ward.

Early confinement and late unlocking had been used regularly and in high frequency in the time before our inspection. Staff regularly reported within incident documentation that early confinement and late unlocking was implements due to “short staffing” and because of “management decisions”. This strategy of restrictive intervention was used by staff and leaders did not proactively review the situation in a timely or effective way to consider alternatives. It had become the normal routine for patients to experience being in their rooms for a long period of time. The impact of this was a lack in socialisation, fresh air and being able to contact friends and family. Activities were cancelled and therapies and therapeutic support for patients was affected. Patients told us it was like prison. Patients told us they knew it was due to lack of staffing but didn’t know when it was going to improve.

A lack of regular supervision meant that staff did not have opportunities to discuss patient care and reflect on how to manage safety in a different way.

During the inspection we found incidents detailed above where restraints and seclusion were used that appeared had become a response rather than using de-escalation techniques as a first resort. The term ‘relational security’ was used by staff as a reason for pre-empting the actions staff would take when managing incidents with particular patients. For example, staff told us that they knew and understood the patients and would predict actions they would take. However, we were not assured by this as detailed above we found incidents of seclusion where they had not only recorded inaccurately but one patient had been secluded numerous times on another ward from where they resided for being loud, although this patient was deaf and could potentially not be aware of the noises and levels of sound they were making. Also, during the inspection we were informed of concerns over the training of management of behaviour which suggested a culture of restrictive practice as a first resort. The trust looked into this and offered assurances that the training offered to staff was not of that nature and was appropriate.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve hospitals.

Action the trust MUST take to improve:

High Secure Hospital

- The trust must ensure that consent to treatment for medicines in completed in line with the Mental health Act Code of Practice. (Regulation 11)
- The trust must ensure that steps are taken to immediately address the low staffing levels at the hospital. (Regulation 12)
- The trust must ensure that restrictive practices such as early confinement and late unlocking are significantly reduced and used only when all other alternatives have been exhausted. (Regulation 12)
- The trust must ensure that patients in seclusion are observed fully in line with trust policy. (Regulation 12)
- The trust must ensure that de-escalation is used before seclusion is used as a last resort and when de-escalation attempts have failed. (Regulation 12)
- The trust must ensure that any deaf patients have access to BSL trained staff to all medical appointments. (Regulation 13)
- The trust must ensure that medicines are accurately titrated within correct timescales according to national guidance. (Regulation 17)
- The trust must ensure there are effective systems and processes in place to monitor the quality of care. (Regulation 17)
- The trust must ensure that they have sufficiently trained, competent, and experienced staff training in British Sign Language, as in national guidance, to meet the needs to the patients. (Regulation 18)

Action the trust Should take to improve:

- The trust should ensure that patient observation records are regularly uploaded into the clinical record system and that technical barriers to this process be improved.

Our inspection team

We carried out this inspection with two inspectors, one senior specialist who had experience working with people with a learning disability and one senior specialist who had experience of working in mental health settings. The inspection team also included one assistant inspector and one specialist advisor.

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 Surgical procedures Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Diagnostic and screening procedures	
Surgical procedures	
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Enforcement actions

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 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing