Waterloo Manor Independent Hospital

Quality Report

Selby Road
Garforth
Leeds
West Yorkshire
LS25 1NA
Tel: 0113 287 6660
Website: www.inmind.co.uk

Date of inspection visit: 19-22 February 2018
Date of publication: 15/06/2018

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	**Good**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

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.

Summary of findings

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 Waterloo Manor Independent Hospital as good because:

- Staff had ensured that patients were fully involved as partners in their care. Feedback from patients about staff attitudes and behaviours was highly positive. Carers were positive about the hospital and told us that they felt appropriately involved in the care delivered by the hospital. Staff supported patients well and encouraged patient led initiatives and events.
- Environmental risks and individual patient risks were assessed and appropriate management plans were in place. Premises and equipment were clean and well looked after. Medications were managed well. Staff understood how to recognise, report and protect patients from abuse. Staff learned from incidents and worked to prevent incidents from happening again.
- There were clear admission criteria. Average lengths of stay were less than national averages for similar services. There was a range of activities available including a fully established and embedded recovery college. Complaints were responded to quickly and appropriately.
- The hospital was well-led. Managers and staff had worked to improve the culture of the hospital since the previous inspection. Managers were visible in the service. There were effective systems in place to ensure good governance. Key performance indicators were effectively used to monitor the service and make improvements. There was a clear commitment to improving the service from all staff.

However,

- There were not enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Lilac ward did not have a qualified nurse working on the ward to provide the right care and treatment.
- Staff were not always recording the level of consciousness of patients following the administration of rapid tranquilisation in line with the hospital policy.
- We found two patients on Maple ward had been administered medication which were not included on the relevant consent to treatment documentation.
- Whilst the hospital had recently introduced a new system for monitoring supervision, staff were not maintaining detailed records of supervision sessions.

Summary of findings

Contents

Good

Waterloo Manor Independent Hospital

Services we looked at

Forensic inpatient/secure wards; Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Waterloo Manor Independent Hospital

Waterloo Manor is an independent psychiatric hospital which provides assessment and treatment for women who have complex mental illnesses, personality disorder and associated needs. The hospital provides three types of services; low secure care, high-dependency rehabilitation services, and a community rehabilitation unit.

The hospital provides two forensic/low secure wards;

- Cedar: a 12 bed low secure ward primarily for patients with a diagnosis of personality disorder
- Maple: a 13 bed low secure ward primarily for patients with a complex mental health illness

The hospital provides three long stay/rehabilitation wards for working age adults:

- Larch: a seven bed high-dependency rehabilitation ward primarily for patients with a diagnosis of personality disorder
- Hazel: an 14 bed high-dependency rehabilitation ward for patients with a diagnosis of personality disorder and/or complex mental health illness
- Lilac: a four bed community rehabilitation unit for patients requiring additional support to support the transition from inpatient services to a community placement

The hospital has been registered with the Care Quality Commission since 2011 to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The hospital had a registered manager and a controlled drugs accountable officer in place at the time of the inspection. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations. Controlled drugs accountable officers are responsible for all aspects of controlled drugs management within their organisation.

We have inspected Waterloo Manor Independent Hospital six times. The last inspection was a focussed inspection of the safe and well-led key questions. At the last inspection in March 2017 we found that the hospital was not meeting all of the Health and Social Care Act (Regulated Activities) Regulations 2014. We issued the provider with two requirement notices. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

The team that inspected the service comprised two CQC inspectors, a CQC pharmacist inspector, a CQC assistant inspector, and four specialist advisors including two registered mental health nurses, a psychologist and a social worker.

Why we carried out this inspection

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

Summary of this inspection

also undertook this inspection to find out whether Waterloo Manor Independent Hospital had made improvements to the service since our last focussed inspection in March 2017.

Following the March 2017 inspection, we told the provider it must take the following actions to improve the service:

- The provider must have systems which ensure accurate and complete records are maintained, cleaning schedules are completed, and contingency plans are in place.
- The provider must ensure that where there is an impact on the patient environment and the patients, for example not having access to hot water or alternative bathing and showering facilities, action is taken to immediately address this.
- The provider must ensure that all patient records, including observation records and medication records are complete and that documentation and storage of that documentation is consistent and in line with guidance provided.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 Safe care and treatment
- Regulation 17 Good governance

We also reported that the provider should take the following actions:

- The provider should record and monitor incidents where patients' escorted leave is cancelled and the reasons why.
- The provider should continue in their efforts to ensure that staff approach is consistent on both day and night shifts.

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 the location
- met on three occasions with the registered manager and corporate management team as part of our ongoing engagement with the provider.

During the inspection visit, the inspection team:

- visited the wards to look at the quality of the environments and observe how staff were caring for patients
- spoke with 16 patients who were using the service
- spoke with four carers of patients who were using the service
- spoke with the hospital director who was the registered manager
- interviewed three ward managers
- interviewed 84 other staff members including catering staff, consultant psychiatrists, domestics, health and safety managers, healthcare support workers, involvement leads, nurses, occupational therapists, occupational therapy assistants, psychologists, psychology assistants, social workers, and social work assistants
- spoke with a contracted pharmacist
- spoke with a NHS England commissioner
- looked at the care and treatment records of 27 patients
- reviewed medication management including the medication administration records of 11 patients
- reviewed six seclusion records
- attended and observed four ward meetings and activities
- reviewed personnel files for six members of staff
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with 16 people who used the service and four carers.

Patients were wholly positive about the staff and the hospital environment. Patients told us that the wards were always clean and tidy. Patients told us that they felt safe on the wards and that staff responded appropriately when there was an incident. Patients praised staff attitudes and behaviours and told us that they felt staff were supportive and caring.

In a number of interviews patients told us that the hospital provided a service which was better than they had received in other hospitals.

Carers were consistently positive about the hospital. Carers told us that they felt appropriately involved in the care provided by the hospital. Carers were really positive about staff, in particular the medical staff. Both patients and carers told us that they felt they could raise concerns and make complaints and that they were confident their complaints would be appropriately dealt with.

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:

- There were not enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Lilac ward did not have a qualified nurse working on the ward to provide the right care and treatment.
- Staff were not always recording the level of consciousness of patients following the administration of rapid tranquilisation in line with the hospital policy.

However,

- Staff assessed risks appropriately. All patients received a comprehensive risk assessment which was regularly updated. Staff assessed risks from the environment appropriately and put plans in place to manage the risks.
- The hospital had suitable premises and equipment and looked after them well.
- Managers provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Staff understood how to protect patients from abuse and the hospital worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply the training.
- The hospital managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Are services effective?

Good

We rated effective as good because:

- All care records had a personalised, holistic care plan which was recovery orientated.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to a paper records system that they could all update.

Summary of this inspection

- The hospital provided care and treatment based on national guidance and evidence of its effectiveness. Patients could access a range of treatments including psychology, occupational therapy and medication.
- The hospital monitored the effectiveness of care and treatment.
- There was a full multidisciplinary team. Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

However,

- Whilst the hospital had recently introduced a new system for monitoring supervision, staff were not maintaining detailed records of supervision sessions.
- Not all staff working in the long stay / rehabilitation service had a good understanding of the Mental Capacity Act.
- We found two patients on Maple ward had been administered medication which were not included on the relevant consent to treatment documentation.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- The hospital consistently demonstrated that people who used the service were truly respected and valued as individuals and were empowered by staff as partners in their care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Feedback from carers praised staff attitudes and behaviours and highlighted how they felt staff consistently exceeded their expectations.
- There was a strong, visible person-centred culture. Patients were encouraged and supported to both participate in and lead activities. There were several examples of how patient feedback was used to direct how services were delivered.
- Staff involved patients and those close to them in decisions about their care and treatment. Care plans reflected the totality of patients' needs. Emotional and social needs were valued by staff and were embedded within care plans and care delivery.
- Staff provided emotional support to patients to minimise their distress.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- The hospital had a clear criteria for admissions. Staff undertook a comprehensive assessment of patients prior to admission to ensure that the service was suitable and addressed patients' needs.
- The average length of stay on one of the hospital's two high-dependency rehabilitation wards was less than the national average for similar services.
- There was a range of activities available including both social and rehabilitation focussed activities. The hospital had successfully implemented a recovery college for patients admitted to both the forensic / low secure wards and the long stay / rehabilitation wards. There was a range of rooms and facilities available in the hospital to support treatment and care.
- Complaints from patients and carers were responded to appropriately. Complaints were investigated quickly. Patients were aware of how to complain and were encouraged and supported to make complaints.

Are services well-led?

Good

We rated well-led as good because:

- The hospital had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The hospital used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The hospital had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The hospital collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The hospital was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Most staff had a good knowledge of the Mental Health Act including knowledge of the guiding principles of the Act. Compliance with Mental Health Act training was above the provider's compliance rate.

Detention paperwork was up to date, appropriately stored and scrutinised. There was administrative support for the Mental Health Act. The service maintained appropriate records of Section 17 leave paperwork and consent to treatment records. Patients had their rights regularly explained to them.

Patients had access to an independent mental health advocacy service.

Mental Capacity Act and Deprivation of Liberty Safeguards

Compliance with mandatory training in the Mental Capacity Act was 97%. Not all staff we interviewed had an understanding of the Mental Capacity Act.

Staff were clear that patients were assumed to have capacity to make decisions. Staff told us that if they had concerns about a patient's capacity then they would inform the consultant psychiatrist or the hospital's social work department.

There were no applications made for Deprivation of Liberty Safeguards in the six months prior to inspection. All patients were detained under the Mental Health Act during this period.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient/ secure wards	Good	Good	☆ Outstanding	Good	Good	Good
Long stay/ rehabilitation mental health wards for working age adults	Requires improvement	Good	☆ Outstanding	Good	Good	Good
Overall	Requires improvement	Good	☆ Outstanding	Good	Good	Good

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Good

Safe and clean environment

Both wards were clean and well-maintained with up to date cleaning records. Ward furniture was of a good quality, clean and well-maintained. Domestic staff had a clear understanding of the daily and weekly cleaning schedules for both wards.

Both wards had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs which staff regularly checked. Controlled drugs were appropriately stored with a controlled drug register kept up to date. Fridge temperatures were checked regularly in line with the provider's policy. Physical health monitoring was undertaken in a separate physical health clinic room which was off the wards. Physical health equipment such as blood pressure machines, electrocardiogram machines, and height and weight scales were clean and working appropriately.

The hospital only admitted female patients which meant that the wards complied with guidance from the Department of Health on eliminating mixed sex accommodation. All bedrooms were en-suite, which included a shower and toilet. There was also a shared bathroom available on both wards where patients could have a bath.

Both wards had an up to date ligature point risk assessment at the time of inspection. A ligature point is anything that could be used to attach a cord, rope or other material, for the purpose of hanging or strangulation. The ward environments were designed to reduce the number of ligature risks. Ligature risk assessments were completed in November 2017. These detailed the individual ligature risks on each ward and the mitigation in place, including through the use of individualised observation levels.

Neither ward had clear lines of sight which allowed staff to observe all areas of the ward. This was mitigated through the use of panoramic convex mirrors at key points and through the use of individualised observation levels. Ligature cutters were kept on both wards and staff were trained to use ligature cutters safely as part of their management of actual or potential aggression training.

There were two seclusion rooms which could be used for patients from both wards. Both seclusion rooms met the guidance of the Mental Health Act Code of Practice. There was a viewing panel and mirrors to allow staff to observe all areas of the rooms, and an intercom which allowed two-way communication. Both rooms had a bathroom facility and a clock.

Staff adhered to infection control principles. Clinic rooms and the physical health clinic room had a sink for staff to wash their hands. There were hand sanitisers available at the entrance to the wards and at the hospital's main entrance. There were regular infection control audits.

Staff had access to personal alarms whilst they worked on the wards. Staff collected and returned their personal alarms at the hospital's main reception at the start and end of their shifts. Nurse call alarms were located in all patient bedrooms and in communal areas on the ward.

Safe staffing

The total number of substantive nursing staff and healthcare support workers for the two wards was 38 whole time equivalents.

Good

Forensic inpatient/secure wards

Staffing data for Cedar ward was:

- qualified nurses establishment level: 6 whole time equivalents
- qualified nurses vacancies: 2.5 whole time equivalents
- qualified nurses vacancy rate (%): 42%
- healthcare support workers establishment level: 16 whole time equivalents
- healthcare support workers vacancies: 0 whole time equivalents
- healthcare support workers vacancy rate: 0%
- total number of substantive staff: 19.5 whole time equivalents
- total number of substantive staff leavers: 1 whole time equivalent
- total vacancies overall (%): 11%
- total sickness overall (%): 4%

Staffing data for Maple ward was:

- qualified nurses establishment level: 4 whole time equivalents
- qualified nurses vacancies: 0.5 whole time equivalents
- qualified nurses vacancy rate (%): 13%
- healthcare support workers establishment level: 18 whole time equivalents
- healthcare support workers vacancies: 3
- healthcare support workers vacancy rate (%): 17%
- total number of substantive staff: 18.5 whole time equivalents
- total number of substantive staff leavers: 3 whole time equivalent
- total vacancies overall (%): 16%
- total sickness overall (%): 5%

Both wards had vacancies for qualified nursing staff. Safe staffing levels were being maintained through the use of bank and agency staff. The hospital maintained its own bank staff roster which meant that bank staff were familiar with the wards. In the period 1 October 2017 to 31 December 2017 bank staff covered 59 shifts on Cedar ward and 119 shifts on Maple ward when there was sickness, absence or vacancies. In the same period agency staff covered 460 shifts on Cedar ward and 359 shifts on Maple ward when there was sickness, absence or vacancies.

The hospital collected data on shifts across the entire hospital and this was not broken down by core service. Across the entire hospital in the same period there were 199 shifts (4%) which were not covered by bank or agency where there shortfall due to sickness, absence or vacancies. The hospital director told us there was an escalation process for where shifts could not be filled which included requesting staff overtime, support from members of the multidisciplinary team and, when required, requesting support from the hospital management team to cover shifts.

On Maple ward the total establishment level for qualified nurses was four whole time equivalents. The whole time equivalent establishment level was based on each qualified nurse working 3.5 shifts reach the total of 14 qualified nurse shifts which needed covering each week (seven day and seven night shifts). The total establishment level for qualified nurses for Maple ward was not high enough to cover staff absence due to annual leave, training and sickness without the use of staff overtime, or bank and agency staff.

There were 40 whole time equivalent staff in the multidisciplinary team, administration team and auxiliary staff. These staff worked across the both low secure wards and the hospital's three long stay / rehabilitation wards.

The hospital closely monitored the use of bank and agency staff. Across the entire hospital in the six months between July and December 2017, agency staff covered on average 36% of the shifts. Bank staff covered 9% of shifts. Over half of the agency usage in the period was to cover for increased observation levels. The hospital director told us that the hospital tried where possible to use block bookings for agency usage so that staff were familiar to the wards. Data supplied by the hospital showed that a quarter of agency use was staff on a medium, or long term, block booking. The wards had an induction process specifically for agency staff which was designed to quickly introduce them to the ward and the patients prior to them starting their shift.

Staff told us that there was always at least one qualified nurse on both wards and were confident that there were always enough staff to carry out physical interventions. We reviewed duty rotas for nursing staff between November 2017 and January 2018. Duty rotas confirmed there was always at least one qualified nurse present on the ward at all times.

Good

Forensic inpatient/secure wards

Patients could access escorted leave and leave was not regularly cancelled due to staffing issues. The hospital had recently completed an audit of cancelled escorted leave for the period October to December 2017 which showed that leave was only cancelled due to patient risks.

The hospital had one consultant forensic psychiatrist and two consultant psychiatrists who worked together to provide on-call cover for all wards. All three psychiatrists told us that they could attend the wards quickly in a mental health emergency. Staff knew how to respond to physical health emergencies.

Mandatory training compliance was good across the entire hospital. Compliance rates were seen to be consistently above the target of 80% for all wards. The overall compliance as of December 2017 was 92%. Mandatory training compliance by module was:

- automated external defibrillator and cardiopulmonary resuscitation: 80%
- anti-discriminatory/diversity: 92%
- fire: 91%
- first aid: 92%
- food hygiene: 95%
- health and safety: 92%
- infection control: 95%
- information governance: 94%
- management of actual or potential aggression: 93%
- medicine management: 100%
- Mental Capacity Act: 97%
- Mental Health Act: 81%
- moving and handling: 95%
- safeguarding: 91%
- security: 100%

Assessing and managing risk to patients and staff

We reviewed 12 care records. The hospital used the Historical Clinical Risk Management-20, version three which is a nationally recognised risk assessment tool. Only one of the records did not have an up to date risk assessment which had been regularly updated. Risk assessments were reviewed following any incidents which involved the patient.

There was a prohibited items list for both wards. Items which were restricted included lighters, sharps, alcohol, and illicit substances. Items such as mobile phones were permitted on the wards subject to individualised risk assessment. Patients and patient bedrooms were searched only when there was a presenting or suspected risk.

The hospital had a process for ensuring that all patients regularly received an explanation of their rights whilst either detained under the Mental Health Act or admitted informally.

The provider submitted data in relation to the use of restrictive interventions including the use of restraint, prone restraint, rapid tranquilisation and seclusion for the period 1 July 2017 to 31 December 2017.

On Cedar ward:

- There were 98 uses of restraint affecting nine service users in total
- There were four uses of prone restraint
- There was one use of prone restraint which resulted in rapid tranquilisation
- There were 49 incidents involving the use of seclusion
- There was one incident of long term segregation.

On Maple ward:

- There were 25 uses of restraint affecting five patients in total
- There was one use of prone restraint
- There were no uses of prone restraint which resulted in rapid tranquilisation
- There was one incident involving the use of seclusion
- There were no incidents of long term segregation.

Staff on both wards consistently told us that restraint was only used as a last resort and only used after de-escalation had failed. Staff told us that the use of prone restraint was strongly discouraged and that they were required to complete additional monitoring information for the use of prone restraint. Prone restraint is holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is face down or has their face to the side. Data supplied by the hospital showed that the hospital monitored the time patients were held in prone restraint. The data showed that prone restraint was used only for a short period of time.

Staff could clearly describe the different levels of observations and completed observation records appropriately.

Good

Forensic inpatient/secure wards

We reviewed six seclusion records which showed that seclusion was used appropriately, following best practice. Patient observations, nursing reviews and medical reviews were completed in line with the Mental Health Act Code of Practice. Seclusion records included a seclusion care plan. Records showed that seclusion was used for the shortest time period possible and was discontinued as soon as patients had settled.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person. An assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Staff were trained in safeguarding and knew how to make a safeguarding alert. Staff could describe the different types of abuse. Nursing staff and managers were aware that the hospital followed the safeguarding assessment matrix. The hospital raised 25 safeguarding referrals to the local authority between 1 January 2017 and 31 December 2017. Between 1 January 2017 and 31 January 2018 the hospital made 35 safeguarding notifications to the CQC. The difference in figures between the safeguarding referrals made to the local authority and the notifications made to CQC was due to the agreed safeguarding assessment matrix used by the local authority to help decision making in relation to making safeguarding referrals. The assessment matrix allowed the hospital to agree potential safeguarding incidents which did not meet the threshold for reporting to the local authority. Under Regulation 18 (registration regulations), the hospital is still required to report these incidents to CQC.

Good medicines management was supported by a range of policies which were regularly reviewed. Medicines were supplied by a specialist hospital pharmacy service or under a service level agreement. A clinical pharmacist visited the wards weekly to review prescription charts; interventions made by the pharmacist were recorded electronically and there was a full audit trail of the actions taken to ensure issues were resolved in a timely manner.

We reviewed 11 medicines charts and patient records in detail and found staff kept accurate records of the treatment patients received. Prescriptions for medicines to be given as or when required contained sufficient information to enable staff to administer them safely.

We reviewed 19 episodes between November 2017 and February 2018 where patients had been given rapid tranquilisation (this is where an injection is given to quickly calm an agitated patient) and found observations had not always been recorded in accordance with national guidance. For example, the level of consciousness and respiratory rate had not been recorded on 11 occasions. In addition, although observations were generally recorded at the frequency recommended in national guidance, staff had not followed the hospital policy which stated they should be recorded every 15 minutes.

Staff undertook appropriate physical health checks for patients prescribed high dose antipsychotic medication. Staff kept records of blood tests, investigations and physical observations in each patient's care plan. The physical health of patients taking antipsychotic medicines was regularly reviewed and monitored in partnership with their registered GP.

Families and children were able to visit the hospital safely. Visitors were not allowed to visit the wards. There was a visitors' room which was off the wards where patients could see their families and children.

Track record on safety

There were 17 serious incidents for the forensic / low secure wards in the period 1 January 2017 to 31 December 2017. The majority of serious incidents related to safeguarding incidents involving patients assaulting other patients.

Providers must report all notifiable serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified. Cedar ward had one incident of apparent/actual/suspected self-inflicted harm meeting the serious incident criteria in the period 1 January 2017 to 31 December 2017. This had been reported to the Strategic Executive Information System.

Good

Forensic inpatient/secure wards

Reporting incidents and learning from when things go wrong

Staff reported incidents using a paper incident reporting form. The forms were then inputted into the provider's electronic incident reporting system. All staff knew how to report an incident and what constituted a reportable incident. All incidents were reviewed first by ward managers and by the multidisciplinary team in the daily morning meeting.

Qualified staff and healthcare support workers could describe the principles of being open and honest if something went wrong, however staff did not consistently recognise this as the duty of candour.

All staff told us that they regularly received a debrief following an incident. Staff debriefs took place immediately after an incident, or shortly after in a handover meeting or a separate incident meeting. Patients received a debrief following an incident. Staff told us that this could either be immediately after the incident, or shortly after in a one to one session if this was more appropriate.

The hospital had recognised a trend in incidents involving deliberate foreign body ingestion. In response the hospital had consulted national guidance, and then written a new deliberate foreign body ingestion policy and procedure. This policy was shared with hospitals within the provider's group and with commissioners from NHS England.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed 12 care records. Care records were maintained to a consistent standard. All care records showed that patients received a comprehensive ongoing assessment which started prior to the patient being admitted to the service. Assessments were holistic; care records showing that patients had psychiatry, nursing, occupational therapy, psychology and social work, assessments. These assessments were used to create a care plan which covered the full range of patient needs.

All care records had a care plan which was personalised and recovery orientated. Care plans started with the patient's personal perspective on the specific area of need which in most cases was written using the patient's own language and phrasing. Where patients had refused to engage with care planning, staff had clearly documented the refusal and still attempted to provide a patient perspective using historical information. Care plans were holistic and covered a range of identified needs. Care plan sections included areas such as mental health, physical health, drug and alcohol use, and living skills.

All care records showed that the service undertook regular physical health monitoring. All patients had their physical health checked on a weekly basis. Staff clearly documented occasions where patients had refused to engage with physical health checks. Care records showed that patients received additional specific care plans in response to ongoing physical health needs such as dental hygiene and diabetes.

All information related to patient care was stored in a paper file which was stored securely on the wards. Care records were organised consistently which meant that information was available and accessible to staff when they needed it.

Best practice in treatment and care

Patients had access to psychological therapies recommended by the National Institute for Health and Care Excellence. The hospital employed a clinical psychologist, a forensic psychologist and two assistant psychologists. Psychological therapies were delivered in group settings or in one to one sessions. Sessions also included other members of the multidisciplinary team where appropriate, such as occupational therapists and social workers. Psychology information leaflets were available for patients.

There was a clear pathway for psychological therapies starting with an assessment phase which could take up to three months. Following the assessment phase there was a treatment phase which could include cognitive behavioural therapy based interventions, cognitive analytical therapy, and interventions which focussed on managing anger, anxiety, emotions and improving insight. There were staff members who were trained to deliver dialectical behavioural therapy skills and groups took place twice a week.

There was good access to physical healthcare including access to specialists when needed. All patients were

registered with a local GP. Care records showed that patients accessed specialist physical healthcare including opticians, dentists, and specialist outpatient clinics such as breast screening clinics and cervical screening clinics.

Staff used recognised rating scales to assess and record severity and outcomes. Care records showed that staff completed the Health of the Nation Outcome Scales for all patients. In one care record a patient had a specific need related to nutrition. Staff had completed the St Andrews Nutritional Screening Instrument which is a simple rating scale designed to identify both malnutrition and obesity.

The hospital had an annual audit schedule. There were 22 audits completed monthly, bi-monthly, quarterly and annually depending on the audit. Seclusion records were audited after each use of seclusion by the hospital director. The hospital provided examples of audits completed in 2017 including an audit of high dose antipsychotic therapy, an audit of how the hospital monitored and cared for the physical health of patients, and a full audit of all Mental Health Act detention paperwork. Completed audits included action plans where there were identified issues and a recommended timescale for repeated audits.

Skilled staff to deliver care

There was a full range of mental health disciplines and staff who provided input to the wards. The hospital employed consultant psychiatrists, healthcare support workers, nurses, occupational therapists, occupational therapy assistants, psychologists, psychology assistants, social workers, and social work assistants.

Data supplied by the hospital showed that compliance rates with annual appraisal was 100% for both Maple and Cedar wards. This was above the compliance target of 80%.

The hospital had introduced a new system for monitoring supervision which showed that staff had received supervision between December 2017 and January 2018. The provider's supervision policy required all staff to receive supervision at least once every three months. Following the inspection the hospital provided evidence which showed that staff received supervision in April 2018.

We reviewed the supervision records of six staff employed by the hospital. The supervision records noted the dates of supervision. The records did not contain detailed records of individual supervision sessions.

The hospital employed three consultant psychiatrists who had all undertaken revalidation.

The hospital had a clear process for inducting new staff to the wards. Newly employed staff were given protected time to complete their mandatory training prior to starting to work on the wards. The wards had an induction process specifically for agency staff which was designed to quickly introduce them to the ward and the patients prior to them starting their shift. Agency staff were trained in the prevention and management of violence and aggression.

Staff could access additional specialist training in addition to their mandatory training. This included training in phlebotomy, personality disorder and dialectical behavioural therapy skills. The hospital had recently trained 30 staff in dissociative identity disorder to specifically care for the needs of the patient group. Staff were supported to undertake recognised qualifications including national vocational qualifications.

The service addressed poor performance promptly and effectively. Four staff had been suspended between January and December 2017. In two cases the investigation had led to the resignation or dismissal of a member of staff.

Multi-disciplinary and inter-agency team work

The multi-disciplinary team had a daily meeting to discuss any changes in patient care from the previous day and the night shift. All patients were reviewed in a ward round meeting which took place every two weeks. There were two handovers per day for nursing staff and healthcare support workers. These took place at the start of each day shift and night shift. Staff told us that the handovers were also used to have debriefs if an incident had occurred during their shift.

The hospital director told us that there were good working relationships with patients' care coordinators, commissioners and with the local authority safeguarding team. Commissioners and care coordinators were invited to care programme approach meetings. Feedback from NHS commissioners was highly positive about hospital staff.

Good

Forensic inpatient/secure wards

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

Qualified staff had a good knowledge of the Mental Health Act including knowledge of the guiding principles of the Mental Health Act. Some healthcare support workers had a good knowledge of the Mental Health Act. Compliance with Mental Health Act training was 81%.

The hospital had three Mental Health Act administrators on site. Staff knew who their Mental Health Act administrators were. Mental Health Act administrators offered support to make sure that the Act was correctly followed including in relation to renewals, appeals against detention and patients receiving an explanation of their rights under the Mental Health Act.

We reviewed consent to treatment documentation and found medicines were not always prescribed in accordance with the provisions of the Mental Health Act. Two patients on Maple ward had been prescribed medicines which were not included on the relevant consent to treatment certificate. We raised this with the nurse in charge who immediately contacted the responsible clinician to review the prescriptions.

There was a clear process for scrutinising Mental Health Act paperwork. We examined a sample of Mental Health Act paperwork for 21 patients across the hospital and found that paperwork was completed and stored appropriately. Section 17 paperwork was in order and stored appropriately. Consent to treatment forms were kept in each patient's medication folder.

Care records showed that patients regularly had their rights under the Mental Health Act explained to them on admission and routinely thereafter.

The hospital completed audits of Mental Health Act paperwork. As a result of the last audit, the hospital had introduced the Mental Health Act scrutiny checklist to reduce the potential for paperwork errors.

Patients had access to an independent mental health advocacy service. The independent mental health advocate visited the hospital three days a week and attended all wards and the fortnightly ward round for each ward.

Good practice in applying the Mental Capacity Act

Compliance with mandatory training in the Mental Capacity Act was 97%. The majority of staff we interviewed had an understanding of the Mental Capacity Act.

Staff were clear that patients were assumed to have capacity to make decisions. Staff told us that if they had concerns about a patient's capacity then they would inform the consultant psychiatrist or the hospital's social work department. The hospital's social work department had a clear understanding of the Mental Capacity Act including in relation to capacity assessments and best interest decisions.

The provider had a policy to support staff in the implementation of the Mental Capacity Act.

There were no applications made for Deprivation of Liberty Safeguards in the six months prior to inspection.All patients were detained under the Mental Health Act during this period.

Are forensic inpatient/secure wards caring?

Outstanding ☆

Kindness, dignity, respect and support

During our inspection we spoke with seven patients admitted to the two forensic / low secure wards and one carer. We also observed interactions between a number of patients and members of staff during four group activities. Throughout the inspection the hospital consistently demonstrated that people who used the service were respected and valued as individuals and were regarded by staff as partners in their care.

Feedback from patients was consistently positive, with patients describing staff as "helpful" and "caring". Throughout our inspection we observed friendly and supportive interactions between staff and patients. Staff members were observed to spend the majority of their time with patients in communal areas of the ward. There were also a number of one to one sessions taking place in private areas on all of the wards during our inspection. One patient commented that they felt the service was superior to any other low secure unit they had experienced. Another patient commented that staff work with them and listen to them.

Good

Forensic inpatient/secure wards

Staff were able to use their in-depth knowledge of the patients in their care to support them appropriately. Staff members were observed to be compassionate and engaged with patients in ways that offered dignity and respect. Staff members were observed to successfully de-escalate a situation whereby a patient had become distressed following a care programme approach review meeting. Staff showed empathy for the patient's situation and calmly explained the rationale for decisions made.

A carer of one patient who had moved from the low secure ward to the rehabilitation wards within the hospital told us that staff continued to show interest in the patients even though they no longer worked with them directly.

Within observed occupational therapy groups, staff members appeared adaptable to the changing needs of patients and were happy to engage in various activities of the patients choosing. Staff spoke to the patients in a kind and respectful manner and ensured that all patients within the group were comfortable and engaged. Staff appeared to have a good understanding of individual patient's needs. For example a staff member was observed to support two patients with reading difficulties to access a questionnaire based on eating habits to ensure they were able to participate fully in the activity.

The involvement of people in the care they receive

At the start of an announced inspection, hospitals are invited to deliver a short presentation to the inspection team. The presentation is designed to give the inspection team an insight into the strengths of the service and to allow the hospital to explain already known areas for improvement. The format for the presentation is intentionally left open for hospitals to decide best how they would like to present their service. The presentation delivered by the hospital was co-authored by patients. Patients told us about the strengths of the service, how the service had benefitted them personally and how patients and staff were partners in the care provided by the hospital.

Partnership working between staff and patients was evident, with a number of group activities directed by patient feedback and identified need. For example; patients identified that they would like a pond within the hospital grounds to provide increased interest during ground leave. Following risk assessments conducted by the staff the installation of the pond then became a group activity, with joint working between patients and staff to choose the site, layout and design.

An occupational therapy group timetable was present in the communal area of each ward. A variety of groups were available with one patient specifically recognising the groups as good, whilst many members of the ward staff commented on the large number and diverse nature of groups available. Patients were also given choice, with a number of different groups often taking place at the same time. The lead occupational therapist also explained that patients were involved in the creation of the group timetable, as they were asked to select from a significant number of activities and highlight which would be of the most interest and benefit to them. Another activity that took place as a result of collaborative working between patients and staff was 'The Wizarding World of Waterloo', an event aimed at encouraging discussions around mental health through the utilisation of a popular fictional story.

Staff and patients explained to us how patients were encouraged to recognise their individual skills and to build their confidence through activities. One patient explained that they are due to deliver a creative writing course to other patients; they shared that staff were highly supportive of her in doing this. Patients were encouraged and supported to take part in activities outside of the hospital. This included college courses, voluntary work and external occupations such as horse riding.

Personalisation of personal spaces was evident throughout the wards. Patients were encouraged to personalise their bedrooms and make them homely environments. There was a clear admission process to orientate patients to the wards which included a patient buddy system.

There was active involvement and participation in care planning. Patients could have a copy of their care plan. In care records we saw that each area of care planning started with the patients' personal perspective on the recognised area of need. In some cases we saw that staff had worked to capture the patient perspective using the patient's own words. If a patient did not wish to be involved in care planning, staff had still worked to record the patients' perspective where possible. The hospital had changed the format of care programme approach reports so that report started with the patient's own description of their mental state and progress. Patients were clearly able to identify family members and carers whom they did and did not want involved in, or informed about, their care within their individualised care plan.

Good

Forensic inpatient/secure wards

Clear attempts had been made to involve families and carers in the care of patients. Following feedback that family members were concerned about the use of restraint with the patients, the Involvement lead created a presentation to provide information and reassurance to families around the use of nationally recognised restraint techniques. Patients and their families also highlighted that they would like an alternative place to visit with one another, other than the internal visiting room. Following this families were invited to help patients create a 'tyre garden' area within the hospital grounds. Additionally the patients had helped to design a newsletter to send out to carers to keep them informed about what was happening at the hospital. Staff highlighted that they would always accommodate visits from families and carers. One patient commented "staff listen to me in relation to my family".

Patients were able to feedback on the service they received through a variety of means. Patients were able to attend 'One Voice' meetings and regular morning meetings on each ward.

Access to advocacy services was clearly advertised in communal areas on each of the wards with patients describing the advocate as "really helpful". All staff members interviewed commented on the frequency of attendance of the advocate to all of the wards. All patients told us that they that knew about their rights under the Mental Health Act.

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

Good

Access and discharge

The average bed occupancy for the period 1 July 2017 to 31 December 2017 was 77.5% for the two wards. Cedar ward had an average bed occupancy for 68%. Maple ward had an average bed occupancy 87%. There was always a bed for patients who returned to the hospital after accessing leave.

The hospital provided data in relation to the average length of stay for current patients and for patients who had been discharged in the period 1 January 2017 to 31 December 2017.

- the average length of stay on Cedar ward for patients currently admitted to the service was 736 days (over two years)
- the average length of stay on Maple ward for patients currently admitted to the service was 803 days (over two years)

The clinical pathway for the service did not automatically transition patients from the low secure wards to the hospital's long stay / rehabilitation wards. Staff told us that discharge plans looked for the most appropriate placement for a patient which could involve transition to the long stay / rehabilitation wards, or to an alternative placement in another inpatient or community setting if this was more appropriate.

Discharge was discussed in fortnightly ward rounds. If a patient was recognised as being within six months of successful discharge then their progress was tracked in the hospital's weekly referrals and discharges meeting. Care records showed that all patients had a discharge plan.

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms and equipment to support treatment and care. Both wards had a communal lounge area and a number of smaller lounges and rooms. There was a skills kitchen on both wards. The hospital had a cinema room, a beauty salon, an occupational therapy room, a recovery college and a gym which patients on all wards could access.

There was a separate room for patients to meet visitors which was off the wards. Both wards had a phone where patients could make a phone call in private. Both wards had an enclosed courtyard where patients could access outside space. Access to the courtyards was not restricted. Both wards had additional gardens with supervised access.

The hospital had a four week menu programme. Patients told us that the food was of a good quality. The catering department ensured that forms were delivered with each meal for patients to provide feedback to the kitchen. The catering department provided all meals unless patients chose to self-cater. The head chef told us that a new menu was soon to be launched in the hospital which included meal options chosen by the patients.

Good

Forensic inpatient/secure wards

Patients had access to hot drinks and snacks. Patients were encouraged to personalise their bedrooms and make them homely environments.

The hospital had worked with patients to successfully implement a recovery college in line with the Commissioning for Quality and Innovation National (CQUIN) goal for medium and low secure services. The hospital's recovery college was called the 'Platinum Circle' to avoid the connection with patients' past experience of education. Patients from both the forensic / low secure wards and the long stay / rehabilitation wards could access sessions in the Platinum Circle.

There was an activities programme which ran every week from Monday to Friday. The hospital had recently employed a new occupational therapist who had implemented the new programme. Prior to the programme the occupational therapist had provided patients with a comprehensive list of options for both social and rehabilitation focussed activities. The activities programme was created in partnership with patients to ensure that the activities on offer were popular.

Meeting the needs of all people who use the service

Both wards were located on the ground floor of the hospital. All areas were accessible for patients who used a wheelchair. Information leaflets were available on all wards. The hospital could access interpreters and/or signers and leaflets in languages other than English.

The service could provide food to meet specific cultural or dietary requirements. Staff told us that patients could be supported to access spiritual support in the community including attending religious places of worship.

Listening to and learning from concerns and complaints

There were 48 complaints relating to the forensic/low secure wards in the twelve months prior to inspection. The majority (42) were from patients admitted to Cedar ward. Cedar ward accounted for over 50% of the total number of complaints received by the hospital in the period. Cedar ward had three complaints which were upheld and Maple ward had two complaints upheld.

There was a clear process for patients to make complaints. Complaints posters and leaflets were available on both wards. The hospital employed a complaints manager who ensured that all complaints were responded to appropriately. On receipt of a complaint, the complaints manager would identify and allocate an investigating officer. There were clear timescales for investigating and responding to complaints. We reviewed three complaints for the low secure / forensic wards. In each case staff had followed the complaints process with a thorough investigation.

Staff told us that they encouraged patients to provide feedback and to make complaints when necessary. The independent mental health advocate told us that she routinely supported patients to raise complaints when required.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

The hospital had a clear statement of vision and values. The hospital vision was:

- To improve and enhance mental and physical health and the wellbeing of everyone we serve through delivering services that match the best in the world.
- We exist to help people reach their individual potential, personal best and live in their community.
- We aim to be the provider of choice for individuals with mental health needs at every stage in their recovery journey.

The provider values were:

- We put people first.
- We put the needs of our service users above all else.
- We are always respectful and honest, open and transparent, to build trust and act with integrity.
- We will constantly improve and aim to be outstanding so we can be relevant today and ready for tomorrow.
- We make commitment to work in partnership so that services can be fully integrated to reflect the needs of service users, carers and communities.
- We enable choice and facilitate the involvement of patients in all aspects of care and day to day life.
- We work directly with service users in the development of our services.

The hospital also had a 'growth tree' which was a pictorial representation of additional values which were locally agreed in consultation with patients and were specific to the hospital. The additional values the 'growth tree' stood for included growth, recovery, ownership, wellness, time, and healing. The majority of staff could not recall the main corporate vision and values, however most staff knew the 'growth tree' and could name one or more of the values which were specific to the hospital.

All staff could name the hospital director and other senior managers in the hospital. Staff told us that the senior managers were highly visible in the hospital.

Good governance

The hospital had effective systems to ensure good governance. The hospital had a 'local integrated governance committee' which met on a monthly basis. This was chaired by the hospital director and attendance included all members of the multidisciplinary team, ward managers, representatives from the nursing staff and healthcare support workers, and a service user representative. We reviewed meeting minutes for the last six months. These included evidence that the hospital had effective oversight of incident themes and trends, the use of restrictive interventions including restraint and seclusion, and key performance indicators such sickness rates, vacancy rates and the use of agency staff.

The provider had a bi-monthly corporate governance meeting which was attended by all hospital directors and chaired by the provider's director of nursing and quality. The corporate governance meeting allowed hospital directors to share lessons learnt from CQC inspections of their services.

Good governance processes ensured that there were enough staff with the right skills and experience and that staff received appropriate mandatory training. Staff were supported to learn from specific incidents and from incident themes. Staff were trained in safeguarding processes and knew how to recognise abuse.

The hospital had sufficient support from administrative staff, as well as three reception staff in post at the time of the inspection. There were three Mental Health Act administrators in post at the time of inspection.

The hospital had a risk register with 13 active risks and one closed risk. The risk register was reviewed in the monthly integrated governance committee. The committee could identify risks which required board-level oversight. Risks requiring board-level oversight were included on the provider's corporate risk register. Three of the risks on the local risk register had been escalated to the board-level corporate risk register including the risk posed by high qualified nurse vacancies.

Leadership, morale and staff engagement

The hospital last undertook a staff survey in August 2017. Results from the survey were not broken down to core service level. The staff survey was based on CQC's five domains (Safe, Effective, Caring, Responsive and Well-led). The staff survey showed high levels of staff satisfaction with the hospital's leadership, morale and engagement. Over 86% of staff responses in the staff survey either agreed or strongly agreed with the statement 'the manager is competent and respected by the staff team' and 75% agreed or strongly agreed that 'senior staff demonstrate positive behaviour and lead by example'.

Staff consistently told us that morale was high and had improved since the last inspection. Staff identified that following the last inspection there had been a culture change within the hospital. A number of staff told us that whilst the culture change had been achieved through a team effort, it had been driven through the work of the hospital director and ward managers. Staff told us there was a strong sense of team work and mutual support within the hospital.

The average sickness rate was 5% which was 1% higher than the 4% average sickness rate for NHS staff. Turnover rates were low with only four substantive members of staff leaving the service in the period 1 January 2017 to 31 December 2017.

There were no reported cases of bullying or harassment under investigation at the time of inspection.

Staff knew how to use the whistleblowing process. The provider had a whistleblowing policy in place, which encouraged staff to raise concerns with the hospital director, senior managers within the corporate organisation or, if required, externally to CQC. Staff consistently demonstrated a clear understanding of the concept of whistleblowing and told us that they would feel confident to raise concerns without fear of victimisation.

Good

Forensic inpatient/secure wards

Commitment to quality improvement and innovation

The hospital had entered both low secure wards into the Royal College of Psychiatry's Quality Network for Forensic Mental Health Services. Staff had completed a number of peer reviews of low secure services and the two wards were due to undergo their peer review in May 2018.

Long stay/rehabilitation mental health wards for working age adults

Good

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Requires improvement

Safe and clean environment

All three wards were clean and well-maintained with up to date cleaning records. Ward furniture was of a good quality, clean and well-maintained. Domestic staff had a clear understanding of the daily and weekly cleaning schedules for all three wards.

Hazel ward and Larch ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs which staff regularly checked. Controlled drugs were appropriately stored with a controlled drug register kept up to date. Fridge temperatures were checked regularly in line with the provider's policy. Physical health monitoring was undertaken in a separate physical health clinic room which was off the wards. Physical health equipment such as blood pressure machines, electrocardiogram machines, and height and weight scales were clean and working appropriately.

Lilac ward did not have a clinic room on the ward. Medicines were stored in a medicines cupboard which also contained locked fridge in the nursing office and could only be accessed by the qualified nurses.

The hospital only admits female patients which meant that the wards complied with guidance from the Department of Health on eliminating mixed sex accommodation. All bedrooms were en-suite, which included a shower and toilet. There was a shared bathroom available on the wards where patients could have a bath.

All three wards had an up to date ligature point risk assessment at the time of inspection. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature risk assessments were completed in November 2017 and detailed the individual ligature risks on each ward and the mitigation in place. On Larch ward and Hazel ward, the ward environments were designed to reduce the number of ligature risks. Where ligature risks remained, these were mitigated through the use of individualised observation levels.

On Lilac ward there were a number of potential ligature risks and the environment did not allow staff to observe all areas of the ward. This was mitigated through an individualised risk assessment of each patient. Ligature cutters were kept on all wards and staff were trained to use ligature cutters safely as part of their management of actual or potential aggression training.

The hospital had two seclusion rooms which could be used by patients. Both seclusion rooms met the guidance of the Mental Health Act Code of Practice. There was a viewing panel and mirrors to allow staff to observe all areas of the room. There was an intercom which allowed two-way communication. Both rooms had a bathroom facility and a clock.

Long stay/rehabilitation mental health wards for working age adults

Good

Staff adhered to infection control audits principles. Clinic rooms and the physical health clinic room had a sink for staff to wash their hands. There were hand sanitisers available at the entrance to the wards and at the hospital's main entrance. There were regular infection control audits.

Staff had access to personal alarms whilst they worked on the wards. Staff collected and returned their personal alarms at the hospital's main reception at the start and end of their shifts. Nurse call alarms were located in patient bedrooms and in communal areas on the ward.

Safe staffing

The total number of substantive qualified nursing staff and healthcare support workers for the three wards was 37.1 whole time equivalents.

Staffing data for Larch ward was:

- qualified nurses establishment level: 4 whole time equivalents
- qualified nurses vacancies: 3 whole time equivalents
- qualified nurses vacancy rate (%): 75%
- healthcare support workers establishment level: 14 whole time equivalents
- healthcare support workers vacancies: 2.5 whole time equivalents
- healthcare support workers vacancy rate (%): 18%
- total number of substantive staff: 12.5 whole time equivalents
- total number of substantive staff leavers: 3
- total vacancies overall (%): 30%
- total sickness overall (%): 5%

Staffing data for Hazel ward was:

- qualified nurses establishment level: 6 whole time equivalents
- qualified nurses vacancies: 0 whole time equivalents
- qualified nurses vacancy rate (%): 0%
- healthcare support workers establishment level: 20 whole time equivalents
- healthcare support workers vacancies: 2.2 whole time equivalents
- healthcare support workers vacancy rate: 11%
- total number of substantive staff: 21.8 whole time equivalents
- total number of substantive staff leavers: 2
- total vacancies overall (%): 9%
- total sickness overall (%): 5%

Staffing data for Lilac ward was:

- qualified nurses establishment level: 0 whole time equivalents
- qualified nurses vacancies: 0 whole time equivalents
- qualified nurses vacancy rate (%): 0%
- healthcare support workers establishment level: 4 whole time equivalents
- healthcare support workers vacancies: 1.2
- healthcare support workers vacancy rate: 30%
- total number of substantive staff: 2.8 whole time equivalents
- total number of substantive staff leavers: 0
- total vacancies overall (%): 30%
- total sickness overall (%): 9%

Lilac had a 30% vacancy rate, however this was due to the small total establishment for this ward. The 30% vacancy rate referred to 1.2 whole time equivalent vacancies out of a total establishment of four whole time equivalents.

On Hazel and Larch wards the total establishment level for qualified nurses was four whole time equivalents. The whole time equivalent establishment level was based on each qualified nurse working 3.5 shifts reach the total of 14 qualified nurse shifts which needed covering each week (seven day and seven night shifts). The total establishment level for qualified nurses for these wards was not high enough to cover staff absence due to annual leave, training and sickness without the use of staff overtime, or bank and agency staff. .

The three wards had vacancies for either qualified nursing staff or for nursing assistants. Safe staffing levels were being maintained through the use of bank and agency staff. The hospital maintained its own bank staff roster which meant that bank staff were familiar with the wards. In the period 1 October 2017 to 31 December 2017 bank staff covered 120 shifts on Larch ward, 186 shifts on Hazel ward and 28 shifts on Lilac ward when there was sickness, absence or vacancies. In the same period agency staff covered 602 shifts on Larch ward, 466 shifts on Hazel ward and 35 shifts on Lilac ward when there was sickness, absence or vacancies.

The hospital collected data on shifts across the entire hospital and this was not broken down by core service. Across the entire hospital in the same period there were 199 shifts (4%) which were not covered by bank or agency where there shortfall due to sickness, absence or vacancies.

Long stay/rehabilitation mental health wards for working age adults

Good

The hospital director told us there was an escalation process for where shifts could not be filled which included requesting staff overtime, support from members of the multidisciplinary team and, when required, requesting support from the hospital management team to cover shifts.

There were 40 whole time equivalent staff in the multidisciplinary team, administration team and auxiliary staff. These staff worked across the three long stay / rehabilitation wards and the hospital's two low secure wards.

The hospital closely monitored the use of bank and agency staff. Across the entire hospital in the six months between July and December 2017, agency staff covered on average 36% of the shifts. Bank staff covered 9% of shifts. Over half of the agency usage in the period was to cover for increased observation levels. The hospital director told us that the hospital tried where possible to use block bookings for agency usage so that staff were familiar to the wards. Data supplied by the hospital showed that a quarter of agency use was staff on a medium, or long term, block booking. The wards had an induction process specifically for agency staff which was designed to quickly introduce them to the ward and the patients prior to them starting their shift.

We reviewed duty rotas for nursing staff between November 2017 and January 2018. Duty rotas confirmed that was always at least one qualified nurse present on Larch and Hazel at all times. Across the hospital there were always at least five qualified nurses working on each shift.

Lilac ward did not meet national guidance in relation to sufficient cover from qualified nursing staff for wards that admit patients either informally or detained under the Mental Health Act. Qualified nursing cover for Lilac ward was provided by two nurses working on Hazel ward. There was not a qualified nurse working on the ward at all times.

Staff were confident that there were always enough staff to carry out physical interventions. Patients could access escorted leave and leave was not regularly cancelled due to staffing issues. The hospital had recently completed an audit of cancelled escorted leave for the period October to December 2017 which showed that leave was only cancelled due to patient risks.

The hospital had three consultant psychiatrists who worked together to provide on-call cover for all wards. All three psychiatrists told us that they could attend the wards quickly in a mental health emergency. Staff knew to respond to physical health emergencies.

Mandatory training compliance was good across the entire hospital. Compliance rates were seen to be consistently above the compliance target of 80% for all wards. The overall compliance as of December 2017 was 92%. Mandatory training compliance by module was:

- automated external defibrillator and cardiopulmonary resuscitation: 80%
- anti-discriminatory/diversity: 92%
- fire: 91%
- first aid: 92%
- food hygiene: 95%
- health and safety: 92%
- infection control: 95%
- information governance: 94%
- management of actual or potential aggression: 93%
- medicine management: 100%
- Mental Capacity Act: 97%
- Mental Health Act: 81%
- moving and handling: 95%
- safeguarding: 91%
- security: 100%

Assessing and managing risk to patients and staff

We reviewed 15 care records. All records had an up to date risk assessment which had been regularly updated. The hospital used the Historical Clinical Risk Management-20, version three and the Short-Term Assessment of Risk and Treatability, which are nationally recognised risk assessment tools. Risk assessments were reviewed following any incidents which involved the patient.

During the inspection we found blanket restrictions on Larch ward. The skills kitchen was kept locked at all times and patients had to ask staff if they wanted to access the kitchen to make hot drinks or snacks. At meal times all patients used plastic cutlery and crockery. This was a new restriction which had been implemented following a significant self-harm incident during the weekend prior to inspection. The restriction was reviewed on a daily basis in the multidisciplinary team meeting. The ward manager and the hospital director told us that restriction was a short-term measure in response to a currently identified risk. We saw in the care records of patients who did not

present a risk in relation to cutlery and crockery that staff had discussed the restriction with the patient and had explored alternative options. Patients who did not present a risk had consented to the restriction after discussion with staff.

There was a prohibited items list for the wards. Items which were restricted included lighters, sharps, alcohol, and illicit substances. Items such as mobile phones were permitted on the wards subject to individualised risk assessment. Patients and patient bedrooms were searched only when there was a presenting or suspected risk.

There were no informal patients admitted to the wards during the inspection. The hospital had a process for ensuring that all patients regularly received an explanation of their rights whilst either detained under the Mental Health Act or admitted informally.

The provider submitted data in relation to the use of restrictive interventions including the use restraint, prone restraint, rapid tranquilisation and seclusion for the period 1 July 2017 to 31 December 2017.

On Larch ward:

- There were 137 uses of restraint affecting six patients in total
- There were no uses of prone restraint
- There were no uses of prone restraint which resulted in rapid tranquilisation
- There were two incidents involving the use of seclusion
- There were no incidents of the use of long term segregation.

On Hazel ward:

- There were 54 uses of restraint affecting six patients in total
- There were no uses of prone restraint
- There were no uses of prone restraint which resulted in rapid tranquilisation
- There were no incidents involving the use of seclusion
- There were no incidents of the use of long term segregation.

On Lilac ward:

- There was one use of restraint affecting one patient
- There were no uses of prone restraint
- There were no uses of prone restraint which resulted in rapid tranquilisation
- There were no incidents involving the use of seclusion
- There were no incidents of the use of long term segregation.

Across all three wards there were 192 uses of restraint affecting 13 patients in total. Over 71% of the uses of restraint were on Larch Ward. There were no uses of prone restraint and no uses of prone restraint which resulted in rapid tranquilisation. There were two incidents involving the use of seclusion which were both on Larch ward. There were no incidents of the use of long term segregation on the long stay / rehabilitation wards.

We reviewed the incident of restraint on Lilac ward and saw that it was managed appropriately by a healthcare assistant and a qualified nurse.

Staff could clearly describe the different levels of observations and completed observation records appropriately.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person. An assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Staff were trained in safeguarding and knew how to make a safeguarding alert. Staff could describe the different types of abuse. Nursing staff and managers were aware that the hospital followed the safeguarding assessment matrix. The hospital raised 25 safeguarding referrals to the local authority between 1 January 2017 and 31 December 2017. Between 1 January 2017 and 31 January 2018 the hospital made 35 safeguarding notifications to the CQC. The difference in figures between the safeguarding referrals made to the local authority and the notifications made to CQC was due to the agreed safeguarding assessment matrix used by the local authority to help decision making in relation to making safeguarding referrals. The assessment matrix allowed the hospital to agree potential

Long stay/rehabilitation mental health wards for working age adults

Good

safeguarding incidents which did not meet the threshold for reporting to the local authority. Under Regulation 18 (registration regulations), the hospital is still required to report these incidents to CQC.

Good medicines management was supported by a range of policies which were regularly reviewed. Medicines were supplied by a specialist hospital pharmacy service under a service level agreement. A clinical pharmacist visited the wards weekly to review prescription charts; interventions made by the pharmacist were recorded electronically and the system maintained a full audit trail of the actions taken to ensure issues were resolved in a timely manner.

We reviewed 11 medicines charts and patient records in detail and found staff kept accurate records of the treatment patients received.

Staff undertook appropriate physical health checks for patients prescribed high dose antipsychotic medication. However, for one patient on Larch ward the monitoring form had not been updated since August 2017 to confirm the appropriate monitoring had been completed. Staff kept records of blood tests, investigations and physical observations in each patient's care plan. The physical health of patients taking antipsychotic medicines was regularly reviewed and monitored in partnership with their registered GP.

Families and children were able to visit the hospital safely. Visitors were not allowed to visit the wards. There was a visitors' room which was off the wards where patients could see their families and children.

Track record on safety

There were seven serious incidents for long stay / rehabilitation wards in the period 1 January 2017 to 31 December 2017. Four of the incidents occurred on Larch ward and three occurred on Hazel ward. There were no serious incidents on Lilac ward.

Providers must report all notifiable serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified. There were no notifiable serious incidents on the three wards in 2017.

Reporting incidents and learning from when things go wrong

Staff reported incidents using a paper incident reporting form. The forms were then inputted into the provider's electronic incident reporting system. All staff knew how to report an incident and what constituted a reportable incident. All incidents were reviewed first by ward managers and by the multidisciplinary team in the daily morning meeting.

Qualified staff and healthcare support workers could describe the principles of being open and honest if something went wrong, however staff did not consistently recognise this as the duty of candour.

All staff told us that they regularly received a debrief following an incident. Debriefs could take place immediately after an incident, or in the handover meeting, or in a separate meeting within days of the incident. Patients received a debrief following an incident. Staff told us that this could either be shortly after the incident or in a one to one session within days of the incident if this was more appropriate.

The hospital had recognised a trend in incidents involving deliberate foreign body ingestion. In response the hospital had consulted national guidance, and then written a new deliberate foreign body ingestion policy and procedure. This policy was shared with hospitals within the provider's group and with commissioners from NHS England.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed 15 care records. Care records were maintained to a consistent standard. All care records showed that patients received a comprehensive ongoing assessment which started prior to the patient being admitted to the service. Care records showed that patients received a number of assessments from psychiatry, nursing, occupational therapy, psychology and social work. These assessments were then used to create a care plan which covered the full range of patient needs.

All care records had a care plan which was personalised and recovery orientated. Care plans started with the patient's personal perspective on the specific area of need which in most cases was written using the patient's own

language and phrasing. Where patients had refused to engage with care planning, staff had clearly documented the refusal and still attempted to provide a patient perspective using historical information. Care plans were holistic and covered a range of identified needs Care plan sections included areas such as mental health, physical health, drug and alcohol use, and living skills.

All care records showed that the service undertook regular physical health monitoring. Patients had their physical health checked on a weekly basis. Staff clearly documented occasions where patients had refused to engage with physical health checks.

All information related to patient care was stored in a paper file which was stored securely on the wards. Care records were organised consistently which meant that information was available and accessible to staff when they needed it.

Best practice in treatment and care

Patients had access to psychological therapies recommended by the National Institute for Health and Care Excellence. The hospital employed a clinical psychologist, a forensic psychologist and two assistant psychologists. Psychological therapies were delivered in group settings or in one to one sessions. Sessions also included other members of the multidisciplinary team where appropriate, such as occupational therapists and social workers. Psychology information leaflets were available for patients.

There was a clear pathway for psychological therapies starting with an assessment phase which could take up to three months. Following the assessment phase there was a treatment phase which could include cognitive behavioural therapy based interventions, cognitive analytical therapy, and interventions which focussed on managing anger, anxiety, emotions and improving insight. There were staff who were trained to deliver dialectical behavioural therapy skills and groups took place twice a week.

There was good access to physical healthcare including access to specialists when needed. All patients were registered with a local GP. Care records showed that patients accessed specialist physical healthcare including opticians, dentists, and specialist outpatient clinics such as breast screening clinics and cervical screening clinics.

Staff used recognised rating scales to assess and record severity and outcomes. Care records showed that staff completed the Health of the Nation Outcome Scales for all patients.

The hospital had an annual audit schedule. There were 22 audits which needed to be completed with monthly, bi-monthly, quarterly and annual timescales depending on the audit. Seclusion records were audited after each use of seclusion by the hospital director. The hospital provided examples of audits completed in 2017 including an audit of high dose antipsychotic therapy, an audit of how the hospital monitored and cared for the physical health of patients, and a full audit of all Mental Health Act detention paperwork. Completed audits included action plans where there were identified issues and a recommended timescale for repeated audits.

Skilled staff to deliver care

There was a full range of mental health disciplines and staff who provided input to the wards. The hospital employed consultant psychiatrists, healthcare support workers, nurses, occupational therapists, occupational therapy assistants, psychologists, psychology assistants, social workers, and social work assistants.

Data supplied by the hospital showed that compliance rates with annual appraisals was 96% overall. Compliance by ward was reported as:

- Larch – 93%
- Hazel – 95%
- Lilac – 100%

The hospital had introduced a new system for monitoring supervision which showed that staff had received supervision between December 2017 and January 2018. The provider's supervision policy required all staff to receive supervision at least once every three months. Following the inspection the hospital provided evidence which showed that staff received supervision in April 2018.

We reviewed the supervision records of six staff employed by the hospital. The supervision records noted the dates of supervision. The records did not contain detailed records of individual supervision sessions.

The hospital employed three consultant psychiatrists who had all undertaken revalidation.

The hospital had a clear process for inducting new staff to the wards. Newly employed staff were given protected time to complete their mandatory training prior to starting to

work on the wards. The wards had an induction process specifically for agency staff which was designed to quickly introduce them to the ward and the patients prior to them starting their shift.

Staff could access additional specialist training in addition to their mandatory training. This included training in phlebotomy, personality disorder and dialectical behavioural therapy skills. The hospital had recently trained 30 staff in dissociative identity disorder to specifically care for the needs of the patient group. Staff were supported to undertake recognised qualifications including national vocational qualifications.

The service addressed poor performance promptly and effectively. Three staff had been suspended between January and December 2017. In two cases the investigation had led to a staff member being redeployed to another area of the hospital.

Multi-disciplinary and inter-agency team work

The multi-disciplinary team had a daily meeting to discuss any changes in patient care from the previous day and the night shift. All patients were reviewed in a ward round meeting which took place every two weeks. There were two handovers per day for nursing staff and healthcare support workers. These took place at the start of each day shift and night shift. Staff told us that the handovers were also used to have debriefs if an incident had occurred during their shift.

The hospital director told us that there were good working relationships with patients' care coordinators, commissioners and with the local authority safeguarding team. Commissioners and care coordinators were invited to care programme approach meetings.

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

Qualified staff had a good knowledge of the Mental Health Act including knowledge of the guiding principles of the Mental Health Act. Some healthcare support workers had a good knowledge of the Mental Health Act, however this was not consistent for all staff we interviewed. Compliance with Mental Health Act training was 81%.

The hospital had three Mental Health Act administrators on site. Staff knew who their Mental Health Act administrators were. Mental Health Act administrators offered support to make sure that the Act was correctly followed including in relation to renewals, consent to treatment, appeals against detention and patients receiving an explanation of their rights under the Mental Health Act.

There was a clear process for scrutinising Mental Health Act paperwork. We examined a sample of Mental Health Act paperwork for 21 patients across the hospital and found that paperwork was completed and stored appropriately. Section 17 paperwork was in order and stored appropriately. Consent to treatment forms were kept in each patient's medication folder.

Care records showed that patients regularly had their rights under the Mental Health Act explained to them on admission and routinely thereafter.

The hospital completed audits of Mental Health Act paperwork. As a result of the last audit, the hospital had introduced the Mental Health Act scrutiny checklist to reduce the potential for paperwork errors.

Patients had access to an independent mental health advocacy service. The independent mental health advocate visited the hospital three days a week and attended all wards and the fortnightly ward round for each ward.

Good practice in applying the Mental Capacity Act

Compliance with mandatory training in the Mental Capacity Act was 97%. Not all staff we interviewed had an understanding of the Mental Capacity Act.

Staff were clear that patients were assumed to have capacity to make decisions. Staff told us that if they had concerns about a patient's capacity then they would inform the consultant psychiatrist or the hospital's social work department. The hospital's social work department had a clear understanding of the Mental Capacity Act including in relation to capacity assessments and best interest decisions.

The provider had a policy to support staff in the implementation of the Mental Capacity Act.

There were no applications made for Deprivation of Liberty Safeguards in the six months prior to inspection. All patients were detained under the Mental Health Act during this period.

The provider had a policy to support staff in the implementation of the Mental Capacity Act.

Long stay/rehabilitation mental health wards for working age adults

Good

Are long stay/rehabilitation mental health wards for working-age adults caring?

Outstanding ☆

Kindness, dignity, respect and support

During our inspection we spoke with nine patients admitted to the long stay / rehabilitation wards and four carers. We also observed interactions between a number of patients and members of staff during four group activities. Throughout the inspection the hospital consistently demonstrated that people who used the service were respected and valued as individuals and were regarded by staff as partners in their care.

Feedback from patients was consistently positive, with patients describing staff as "really nice", "really visible" and "caring and respectful". Throughout our inspection we observed friendly and supportive interactions between staff and patients. Staff members were observed to spend the majority of their time with patients in communal areas of the ward. There were also a number of one to one sessions taking place in private areas on all of the wards during our inspection. One patient commented that they felt "staff go out of their way to do things for us" whilst another commented "staff are always there to talk to if I need them".

Patients also commented on the compassionate and respectful natures of staff members, including comments such as "staff always handle difficult situations well" as well as "staff never do things without discussing it with me first". A member of staff also described a situation whereby a patient had been incontinent in a communal area, and how the staff had gone out of their way to ensure the patient did not feel embarrassed and instead offered the patient access to the hospital salon in order for her to feel positive about herself.

Carers were also positive with regards to staff members, with comments received including "we are majorly impressed with them", "staff can't do enough for us or her" and "staff are always really respectful to us and the patient". Two carers commented on how staff members were also supporting patients to maintain good physical health.

Staff were able to use their in-depth knowledge of the patients in their care to support them appropriately. Staff members were observed to be compassionate and engage with patients in ways that offered dignity and respect. Within observed occupational therapy groups staff members appeared adaptable to the changing needs of patients and were happy to engage in various activities of the patients choosing. Staff spoke to the patients in a kind and respectful manner and ensured that all patients within the group were comfortable and engaged. Staff appeared to have a good understanding of individual patient's needs.

Specific praise for the on-site doctors was also given by both patients and carers. One carer commented that the doctor "addressed all my concerns and explained all the pros and cons of my daughter's medications, he can't be faulted". Patients highlighted that they were given choices with regards to medications whilst ward staff members stated that medication would always be discussed with patients and personal preference would be taken into account.

The involvement of people in the care they receive

At the start of an announced inspection, hospitals are invited to deliver a short presentation to the inspection team. The presentation is designed to give the inspection team an insight into the strengths of the service and to allow the hospital to explain already known areas for improvement. The format for the presentation is intentionally left open for hospitals to decide best how they would like to present their service. The presentation delivered by the hospital was co-authored by patients. Patients told us about the strengths of the service, how the service had benefitted them personally and how patients and staff were partners in the care provided by the hospital.

Partnership working between staff and patients was evident, with a number of group activities directed by patient feedback and identified need. For example; patients identified that they would like a pond within the hospital grounds to provide increased interest during ground leave. Following risk assessments conducted by the staff the installation of the pond then became a group activity with joined working to decide the layout and content. The lead occupational therapist also explained that patients were involved in the creation of the group timetable, as they were asked to select from a significant number of activities and highlight which would be of the most interest and benefit to them. Another activity that

Long stay/rehabilitation mental health wards for working age adults

Good

took place as a result of collaborative working between patients and staff was 'The Wizarding World of Waterloo', an event aimed at encouraging discussions around mental health through the utilisation of a popular fictional story.

Staff and patients alike also explained to us how patients were encouraged to recognise their individual skills and to build their confidence through activities. Patients were encouraged and supported to take part in activities outside of the hospital. This included college courses, voluntary work and external occupations such as horse riding.

Patients were able to feedback on the service they received through a variety of means including via attendance at 'One Voice' meetings and regular morning meetings on each ward. Feedback forms for the food provided to patients were also visible on all wards. We saw evidence of written patient feedback following groups led by the occupational therapy department. Complaints procedures and forms were visible within communal areas on each ward. Patients and carers alike highlighted that they knew how to complain should they wish to. Staff members were clear in stating that if patients did complain they would still be treated with dignity and respect. One patient interviewed stated that they had previously complained and felt that staff dealt with the complaint fairly.

Clear attempts had been made to involve families and carers in the care of patients. Following feedback that family members were concerned about the use of restraint with the patients the Involvement Lead created a presentation to provide information and reassurance to families around the use of nationally recognised restraint techniques. Patients and their families also highlighted that they would like an alternative place to visit with one another, other than the internal visiting room. Following this families were invited to help patients create a 'tyre garden' area within the hospital grounds. Additionally the patients had helped to design a newsletter to send out to carers to keep them informed about what was happening at the hospital. Staff highlighted that they would always accommodate visits from families and carers. Within care plans involvement of carers in discharge plans was evident, including their views on placements identified. Patients were aware of their ability to choose whether their families were involved in their care with one patient commenting "I want my family to be informed but not involved and this is my choice".

Personalisation of personal spaces was evident throughout the wards. Patients were encouraged to personalise their bedrooms and make them homely environments. There was a clear admission process to orientate patients to the wards which included a patient buddy system.

There was active involvement and participation in care planning. Patients could have a copy of their care plan. In care records we saw that each area of care planning started with the patients' personal perspective on the recognised area of need. In some cases we saw that staff had worked to capture the patient perspective using the patient's own words. If a patient did not wish to be involved in care planning, staff had still worked to record the patients' perspective where possible. The hospital had changed the format of care programme approach reports so that report started with the patient's own description of their mental state and progress. Patients were clearly able to identify family members and carers whom they did and did not want involved in, or informed about, their care within their individualised care plan.

Access to advocacy services was clearly advertised in communal areas on each of the wards with patients describing the advocate as "supportive, patient and helpful" whilst another shared that the advocate would attend ward round with them in order to provide support. All staff members interviewed commented on the frequency of attendance of the advocate to all of the wards. Patients stated that knew about their rights under the mental health act and were reminded of these regularly.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

The average bed occupancy for the period 1 July 2017 to 31 December 2017 was 82% for the three wards. Larch ward had an average bed occupancy of 100%. Hazel ward had an average bed occupancy of 88%. Lilac ward had an average bed occupancy of 58%. There was always a bed for patients who returned to the hospital after accessing leave.

Long stay/rehabilitation mental health wards for working age adults

Good

The hospital provided data in relation to the average length of stay for current patients and for patients who had been discharged in the 12 months prior to inspection.

- the average length of stay on Larch ward for patients currently admitted to the service was 296 days (less than one year)
- the average length of stay on Hazel ward for patients currently admitted to the service was 469 days (less than two years)
- the average length of stay on Lilac ward for patients currently admitted to the service was 248 days (less than one year)

The average length of stay for Larch ward, one of the hospital's high-dependency rehabilitation wards was less than the national average length of stay for similar wards (341 days). This is good practice. Long average lengths of stay on high-dependency rehabilitation wards was highlighted as an area of concern in CQC's report on 'The State of Care in Mental Health Services 2014 to 2017'.

The service was routinely used to admit patients from outside the local area. Patients were admitted to the service from the hospital's low secure wards and low secure wards of other providers, acute mental health wards and long stay / rehabilitation wards.

Discharge was discussed in fortnightly ward rounds. If a patient was recognised as being within six months of successful discharge then their progress was tracked in the hospital's weekly referrals and discharges meeting. Care records showed that all patients had a discharge plan.

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms and equipment to support treatment and care. Both wards had a communal lounge area and a number of smaller lounges and rooms. There was a skills kitchen on both wards. The hospital had a cinema room, a beauty salon, an occupational therapy room, a recovery college and a gym which patients on all wards could access.

There was a separate room for patients to meet visitors which was off the wards. Both wards had a phone where patients could make a phone call in private. Both Hazel and Larch wards had an enclosed courtyard where patients could access outside space. Access to the courtyards was not restricted. Lilac had open access to outside space.

Food was provided by the hospital to Larch ward and Hazel ward. The hospital had a four week menu programme. Patients told us that the food was of a good quality. The catering department ensured that forms were delivered with each meal for patients to provide feedback to the kitchen. The catering department provided all meals unless patients chose to self-cater. The head chef told us that a new menu was soon to be launched in the hospital which included meal options chosen by the patients.

Lilac ward focussed on self-catering as part of the rehabilitation programme. The hospital provided patients with a weekly budget to support patients to self-cater.

Patients on Larch ward and Hazel ward had access to hot drinks and snacks. On Lilac ward there was an open kitchen for patients to use. Patients were encouraged to personalise their bedrooms and make them homely environments.

The hospital had worked with patients to successfully implement a recovery college in line with the Commissioning for Quality and Innovation National (CQUIN) goal for medium and low secure services. The hospital's recovery college was called the 'Platinum Circle' to avoid the connection with patients' past experience of education. Patients from both the forensic / low secure wards and the long stay / rehabilitation wards could access sessions in the Platinum Circle.

There was an activities programme which ran every week from Monday to Friday. The hospital had recently employed a new occupational therapist who had implemented the new programme. Prior to the programme the occupational therapist had provided patients with a comprehensive list of options for both social and rehabilitation focussed activities. The activities programme was created in partnership with patients to ensure that the activities on offer were popular.

Meeting the needs of all people who use the service

Larch ward was located on the ground floor of the hospital and all areas were accessible for patients who used a wheelchair. Hazel and Lilac ward had two floors. The upper floor was not accessible for patients who used a wheelchair; however there was a ground floor bedroom for disabled patients.

Long stay/rehabilitation mental health wards for working age adults

Good

Information leaflets were available on all wards. The hospital could access interpreters and/or signers and leaflets in languages other than English.

The service could provide food to meet specific cultural or dietary requirements. Staff told us that patients could be supported to access spiritual support in the community including attending religious places of worship.

Listening to and learning from concerns and complaints

There were 33 complaints for this core service in the twelve months prior to inspection. Larch ward had 15 complaints of which four were upheld, Hazel ward had 14 complaints of which three were upheld, and Lilac ward had four complaints of which one was upheld.

There was a clear process for patients to make complaints. Complaints posters and leaflets were available on all wards. The hospital employed a complaints manager who ensured that all complaints were responded to appropriately. On receipt of a complaint, the complaints manager would identify and allocate an investigating officer. There were clear timescales for investigating and responding to complaints. We reviewed three complaints for the long stay / rehabilitation wards. In each case staff had followed the complaints process with a thorough investigation.

Staff told us that they encouraged patients to provide feedback and to make complaints when necessary. The independent mental health advocate told us that she routinely supported patients to raise complaints when required.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

Vision and values

The hospital had a clear statement of vision and values. The hospital vision was:

- To improve and enhance mental and physical health and the wellbeing of everyone we serve through delivering services that match the best in the world.
- We exist to help people reach their individual potential, personal best and live in their community.
- We aim to be the provider of choice for individuals with mental health needs at every stage in their recovery journey.

The provider values were:

- We put people first.
- We put the needs of our service users above all else.
- We are always respectful and honest, open and transparent, to build trust and act with integrity.
- We will constantly improve and aim to be outstanding so we can be relevant today and ready for tomorrow.
- We make commitment to work in partnership so that services can be fully integrated to reflect the needs of service users, carers and communities.
- We enable choice and facilitate the involvement of patients in all aspects of care and day to day life.
- We work directly with service users in the development of our services.

The hospital also had a 'growth tree' which was a pictorial representation of additional values which were locally agreed in consultation with patients and were specific to the hospital. The additional values the 'growth tree' stood for included growth, recovery, ownership, wellness, time, and healing. The majority of staff could not recall the main corporate vision and values, however most staff knew the 'growth tree' and could name one or more of the values which were specific to the hospital.

All staff could name the hospital director and other senior managers in the hospital. Staff told us that the senior managers were highly visible in the hospital.

Good governance

The hospital had effective systems to ensure good governance. The hospital had a 'local integrated governance committee' which met on a monthly basis. This was chaired by the hospital director and attendance included all members of the multidisciplinary team, ward managers, representatives from the nursing staff and healthcare support workers and a service user representative. We reviewed six month's meeting minutes. Meeting minutes included evidence that the hospital had effective oversight of incident themes and trends, the use of restrictive interventions including restraint and seclusion, and key performance indicators such sickness rates, vacancy rates and the use of agency staff.

Long stay/rehabilitation mental health wards for working age adults

Good

The provider had a bi-monthly corporate governance meeting which was attended by all hospital directors and chaired by the provider's director of nursing and quality. The corporate governance meeting allowed hospital directors to share lessons learnt from CQC inspections of their services.

Good governance processes ensured that there were enough staff with the right skills and experience and that staff received appropriate mandatory training. Staff were supported to learn from specific incidents and from incident themes. Staff were trained in safeguarding processes and knew how to recognise abuse.

During the inspection we identified that not all staff had a good awareness of the Mental Capacity Act. This was despite high levels of compliance with Mental Capacity Act training.

The hospital had sufficient support from administrative staff. There were three Mental Health Act administrators in post at the time of inspection. There were three reception staff in post at the time of the inspection.

The hospital had a risk register in place at the time of inspection. There were 13 active risks on the risk register and one closed risk. The risk register was reviewed in the monthly integrated governance committee. The committee could identify risks which required board-level oversight. Risks requiring board-level oversight were included on the provider's corporate risk register. Three of the risks on the local risk register had been escalated to the board-level corporate risk register including the risk posed by high qualified nurse vacancies

Leadership, morale and staff engagement

The hospital last undertook a staff survey in August 2017. Results from the survey were not broken down to core service level. The staff survey was based on CQC's five domains (Safe, Effective, Caring, Responsive and Well-led). The staff survey showed high levels of staff satisfaction with the hospital's leadership, morale and engagement. Over 86% of staff responses in the staff survey either agreed or strongly agreed with the statement 'the manager is competent and respected by the staff team' and 75% agreed or strongly agreed that 'senior staff demonstrate positive behaviour and lead by example'.

Staff consistently told us that morale was high and had improved since the last inspection. Staff identified that following the last inspection there had been a culture change within the hospital. A number of staff told us that whilst the culture change had been achieved through a team effort, it had been driven through the work of the hospital director and ward managers. Staff told us there was a strong sense of team work and mutual support within the hospital.

The average sickness rate was 6% which was 2% higher than the 4% average sickness rate for NHS staff. Lilac had the highest sickness rate at 9%. Turnover rates were low with only four substantive members of staff leaving the service in the 12 months prior to inspection.

There were no reported cases of bullying or harassment under investigation at the time of inspection.

Staff knew how to use the whistleblowing process. The provider had a whistleblowing policy in place. This was implemented in March 2016 and was not due for review until March 2018. The policy encouraged to raise concerns with the hospital director, senior managers within the corporate organisation or, if required, externally to CQC. Staff consistently demonstrated a clear understanding of the concept of whistleblowing and told us that they would feel confident to raise concerns without fear of victimisation.

Commitment to quality improvement and innovation

In 2017 the hospital became one of the few independent mental health hospitals to achieve teaching hospital status. The first medical students from the University of Leeds started their placements in the hospital in September 2017 on the hospital's long stay / rehabilitation wards. The hospital told us that placements offer students an insight into the presentation and management of a range of complex mental illnesses and personality disorders. The placement programme was praised in the 2016/17 annual report from the Leeds Institute of Medical Education which noted that there was excellent feedback from both students and staff at the end of the first rotation.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had worked with patients to successfully implement a recovery college in line with the Commissioning for Quality and Innovation National (CQUIN) goal for medium and low secure services. The hospital's recovery college was called the Platinum Circle to avoid the connection with patients' past experience of education. Patients from both the forensic / low secure wards and the long stay / rehabilitation wards could access sessions in the Platinum Circle. In July 2017, the Platinum Circle was featured in a presentation to the Yorkshire and Humber Involvement Network which brings together both NHS and independent sector low and medium secure services. The presentation to the network was co-delivered by staff and patients from the hospital.
- The hospital employed a full time involvement lead who was responsible for ensuring that all wards worked innovatively to engage and involve patients in their care. During the inspection we saw that staff ensured patients were truly partners in their care. Patients were supported to attend a number of national events including the National Recovery and Outcome Conference and the National Service User Awards. The involvement lead had worked with patients to organise a number of fun events at the hospital. At the time of inspection the hospital was a finalist for two National Service User Awards: 'Community, Social or Vocational Initiative' and 'Recovery and the Arts'.
- The hospital had recently become one of the few independent mental health hospitals to achieve teaching hospital status. The hospital worked in partnership with the University of Leeds to provide placements for medical students specialising in psychiatry. Students were given an insight into how the service cared for patients with complex mental health needs and personality disorders who were on a rehabilitation pathway.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure sufficient numbers of suitably qualified, competent, skilled and experienced nurses are deployed on Lilac ward.

Action the provider SHOULD take to improve

- The provider should ensure that staff have a thorough understanding of the rapid tranquilisation policy to support safe administration and monitoring of rapid tranquilisation.
- The provider should review the establishment levels to ensure that there are sufficient numbers of permanently employed suitably qualified, competent, skilled and experienced nursing staff on all wards.
- The provider should continue to ensure that all staff receive appropriate supervision in line with the provider's supervision policy. Supervision records must be maintained appropriately.
- The provider should ensure that all staff have an understanding of the Mental Capacity Act.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced nurses were deployed on Lilac ward. **This was a breach of Regulation 18(1)(2)(a)**