Waterloo Manor Independent Hospital

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Overall summary

We rated Waterloo Manor Independent Hospital as requires improvement overall because:

At this inspection, we found areas of concern in the safe and well-led domains.

- The provider had not risk assessed the impact on the patient environment and the patients where a boiler had broken and patients' did not have access to hot water, or find alternative washing facilities.

Summary of findings

- Some patient records were incomplete, including observation records and medication records, and documentation and storage of that documentation was inconsistent and not always in line with guidance provided.
- Not all systems and processes in place to ensure patients were safe and that treatment and care was effective were robust or effective. This included systems to ensure that accurate and complete records were maintained, cleaning schedules were completed, and contingency plans were in place.

However,

- During this most recent inspection, we found that the service had addressed the breach of regulation that had caused us to rate safe as requires improvement following the June 2016 inspection. All the wards were clean at the time of this inspection.
- Waterloo Manor was now meeting Regulations 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- Following our inspection in June 2016, we rated the location as good for effective, caring and responsive. Since that inspection we have received no information that would cause us to re-inspect these key questions or change these ratings.
- Staffing levels across the hospital were adequate and ensured patient need was met. Recruitment was ongoing and the hospital continued to use bank and agency staff to fill any staffing shortfalls.
- The level of engagement and involvement of patients with regional involvement groups and the recovery college was encouraged and supported by staff. Patients attended meetings and contributed positively to projects within the hospital.
- Staff gave positive feedback about the management of the hospital. They said there had been some changes since our last inspection which they felt were positive. They told us management were approachable and they felt able to raise issues and concerns.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Location	Requires improvement 	Start here...
Forensic inpatient/ secure wards	Requires improvement 	Start here...
Long stay/ rehabilitation mental health wards for working-age adults	Requires improvement 	Start here...

Summary of findings

Contents

Requires improvement

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 Independent Hospital is registered with the Care Quality Commission to carry out the following regulated activities:

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

Waterloo Manor is an independent psychiatric hospital that provides assessments and treatments for women who have complex mental illnesses and associated needs. The hospital provides both low secure care and a rehabilitation service.

The hospital consists of three low secure wards: Cedar (12 beds), Maple (13 beds) and Larch (8 beds).Three locked rehabilitation wards: Beech (6 beds), Holly (4 beds), Hazel

(8 beds). One open rehabilitation ward: Lilac (5 beds). The hospital has a total of 56 beds. At the time of our inspection there were 41 patients at the hospital. At the time of inspection Holly ward was closed and did not have patients admitted.

A registered manager was in place at the location. 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, including the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010.

When the CQC inspected the location in June 2016, we found one breach of regulation. We issued the provider with one requirement notice. This related to the following regulation under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment.

Our inspection team

Team leader: Emma Hatfield, Inspector, Care Quality Commission

The team that inspected the service comprised of three Care Quality Commission inspectors.

Why we carried out this inspection

We undertook this inspection in response to us receiving information of concern relating to the safe and well-led domains. We also took the opportunity to find out whether Waterloo Manor had made improvements since our last comprehensive inspection of the hospital in June 2016.

The concerns related to

- Patient safety
- The environment, including no hot water in the hospital
- Staffing and staff training
- Medication related issues
- Leadership and governance concerns

When we last inspected the service in June 2016, we rated the service as good overall. We rated the service as requires improvement for safe, and good for effective, caring, responsive and well-led.

Following the June 2016 inspection, we told the provider it must make the following actions to improve the service:

- The provider must ensure the environment is clean.

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

Summary of this inspection

- Regulation 15 Premises and equipment

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. This information suggested that the ratings of good for effective, caring and responsive, that we made following our June 2016 inspection, were still valid. Therefore, during this inspection, we focused on those issues that had caused us to rate the service as requires improvement for safe. We also focused on the issues raised in the information we received about the service relating to the safe and well-led domains. We also sampled some of the actions we reported that the provider should do at the location.

During the inspection visit, the inspection team:

- visited all wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service
- spoke with the registered manager and managers or acting managers for each of the wards
- spoke with nine other staff members; including doctors, nurses, an occupational therapist, a psychologist and a social worker
- received feedback about the service from one social worker
- attended and observed two hand-over meetings and two multi-disciplinary meetings
- looked at 10 care and treatment records of patients
- carried out a specific check of the medication management on one ward
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with nine patients from across the hospital.

We received negative feedback from eight of the nine patients we spoke with about the attitude of the night staff at the hospital. All eight patients told us there was a big difference between how the night staff treated them in comparison to how the day staff treated them. We reported this to the registered manager.

We received mixed feedback about the quality of food. One patient told us the food was cold if you ate at the second sitting. Another patient told us that on admission, they had been visited by the chef who asked them their preferences.

All patients all spoke highly about the activities on offer however, some told us they felt disappointed when they could not access leave outside the hospital.

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 re-rated safe as **requires improvement** because:

- The provider had not risk-assessed the impact on patients not having access to hot water or alternative bathing and showering facilities.
- Observation records on Larch ward were incomplete and the observation documentation was not used or stored consistently.
- Staff used a coding system in the observation records which was not identified or defined on the document or in the service's guidance to record the patient whereabouts.
- Staff on Larch ward were using codes on medication administration records which were different from the coding system indicated on the record. Where patients had refused medicines, staff had not recorded additional information about the refusal as was required.

However:

- During this most recent inspection, we found that the service had addressed the breach of regulation that had caused us to rate safe as requires improvement following the June 2016 inspection. All the wards were clean at the time of this inspection.
- At the last inspection in June 2016, we recommended that the provider should take action to ensure that blind spots were mitigated, including on the bedroom corridors. At this inspection the provider had taken action to address this with the installation of mirrors.
- Wards looked clean and we saw patient's had the opportunity to personalise their bedroom and communal ward areas.
- One patient on Larch ward had written their own guidance for staff which stated how they wanted their observations to be carried out and what their risks were.
- The required equipment and medication were available and accessible. The staff members had alarms and knew how to respond to incidents and the number of staff on shift was adequate to meet the needs of patients.

Are services effective?

Good 

At the last inspection in June 2016 we rated **effective** as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Summary of this inspection

Are services caring?

Good

At the last inspection in June 2016 we rated **caring** as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive?

Good

At the last inspection in June 2016 we rated **responsive** as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Systems and processes were not effective or sufficiently robust to ensure that accurate records were maintained, including observation and medication records.
- Systems were not in place to identify that cleaning schedules were not being completed on Larch ward, or the gaps in the completion of the cleaning schedules on Lilac and Hazel.
- The service had not identified a contingency plan for patients' hygiene and comfort needs in response to the ongoing boiler problems.

However,

- The hospital had a 'local integrated governance committee' which allowed the senior leadership team to have oversight of the hospital performance. Key performance indicators were reviewed monthly in local integrated governance committee meetings.
- The hospital had effective systems in place to ensure staff received mandatory training, supervision and appraisals.

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.

We did not review the service's adherence to the Mental Health Act during this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the service's adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards during this inspection.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

At the last inspection in June 2016, we found that not all wards were clean. Maple ward had several areas that were unclean. The provider sent us an action plan telling us how they would address this.

On this inspection, we visited all of the wards at the hospital and found they were all clean. Patient's had the opportunity to personalise their bedroom and communal ward areas. Improvements had been made to the cleaning schedules and they now contained more detailed instructions for domestic staff on cleaning tasks. Once cleaning tasks had been completed, staff were required to sign the schedules.

However, we were told by domestic staff they had been unable to complete any cleaning schedules for Larch ward for the six week period the ward had been open, as they had been too busy. We found gaps on the cleaning schedules for Hazel and for Lilac. Between the 9 January 2017 and 30 January 2017 for Hazel, we saw a total of 37 tasks had not been signed as completed. On Lilac ward, between 11 January 2017 and 25 January 2017 there were 11 tasks which had not been signed as completed. Therefore, although wards were clean at the time of our inspection, staff's failure to complete the cleaning schedules meant it was not clear if all required cleaning had been carried out.

Prior to the inspection, we received information of concern which stated there had been no hot water available for patients for a period of three weeks. We were told that patients had been using cold water for bathing and showering. We spoke with the registered manager at the service who confirmed there was an issue with the boilers on site. They told us that there had been two incidents where the service did not have hot water in the last three weeks. At the time of the inspection all wards except Lilac did not have hot water. We were told by the registered manager that one patient had made a complaint in writing about this issue. Also, some patients were asking staff regularly as to any progress on this matter. We looked at emails and order forms dated between 8 February 2017 and 1 March 2017. These showed there had been ongoing issues and parts had been ordered. Both the registered manager and the maintenance staff member told us updates had been sought on a regular basis.

The maintenance staff member completed monthly water temperature checks on outlets across the hospital. We reviewed records for checks carried out in February 2017 and saw temperatures across the hospital varied. At their lowest, temperatures on Beech ward were recorded as 22 degrees centigrade for hand wash basins and showers. On water check records for Lilac ward we saw temperatures were recorded as 40 degrees centigrade for hand wash basins and showers. The maintenance manager confirmed that patients on that ward had access to hot water as this was served by a separate boiler.

The impact on patients not having access to hot water or alternative bathing and showering facilities had not been risk-assessed. We asked if the service had considered the impact of this issue on the patients and whether alternative arrangements had been made, for example patients being offered the use of the facilities on Lilac ward. The registered

manager told us this had not been done. Before we left the hospital, the registered manager told us they had discussed the issue further with other senior managers on site and were going to offer this facility to all of the patients.

At the last inspection in June 2016, we recommended that the provider should take action to ensure that blind spots were mitigated, including on the bedroom corridors. At this inspection the service had taken action to address this with the installation of mirrors.

The staff members had alarms and knew how to respond to incidents.

Safe staffing

We reviewed staffing rotas and saw staffing levels across the hospital were adequate to meet patient need. We saw staff were present and visible on all of the wards and patients told us staff spent time with them in communal areas of the wards. The registered manager told us they increased staffing levels when there was an increase in the needs of the patients. Staffing levels were often maintained using regular bank and agency staff. Agency staff were often 'block booked' by the hospital to ensure consistency for the patients and that staff were familiar with the service. Agency staff received an induction prior to working at the hospital and had completed the required mandatory training.

- At the time of this inspection there were 20 whole time equivalent qualified nurses in post and eight vacancies. There were 62 whole time equivalent nursing assistants in post and three vacancies. The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies between 01 October 2016 and 31 December 2016 consisted of 205 agency and 416 bank staff. Twenty-four shifts had not been filled by bank or agency staff where there was sickness, absence or vacancies for the same time period.
- The service had a total of 111 permanent staff and 150 bank staff. The staff turnover rate from 01 September 2016 to 28 February 2017 was 11 substantive staff. The sickness rate for this time period was 3%.

The registered manager told us recruitment was on-going to address all vacancies. The registered manager told us that the service was making attempts to recruit to all vacancies and would continue with this until all posts were filled.

The hospital measured compliance with mandatory training on a month by month basis. The target for compliance is 80%. Data we reviewed showed average compliance overall from August 2016 to January 2017 was 92%. None of the modules were below the target which meant staff who worked at the hospital had completed all of the training they required for their role.

Assessing and managing risk to patients and staff

We reviewed 10 patient records and found they all contained up to date comprehensive risk assessments. Risk management plans were in place which provided staff with clear guidance on how to manage the risks identified. These included physical health, and risk to self and others. We saw staff reviewed the risk assessments on a regular, monthly basis and updated them when an incident had occurred. A historical clinical risk management tool was completed and regularly reviewed for every patient.

We saw a number of patients across the hospital were on increased levels of observations. This meant that in response to risks identified, they were supported and observed by staff at designated intervals. Staff told us they used these documents to ensure that they were up to date with the patients' needs when they were being observed.

On Larch ward, we reviewed records of observation for all six patients. Staff told us there was a 'management plan' for observation levels in place for each patient which clearly identified the level of risks and support the patient needed. These records were stored in different places for each patient. For example, two plans were in the patients care record, two were in the observation file and two other management plans had been completed on documents with different titles such as a My shared pathway care plan. Therefore observation documentation and the storage of that documentation on Larch Ward was not consistent and may mean that staff are unable to locate that documentation easily when required.

Our review of the observation records on Larch Ward also showed that staff had not completed all of the required areas of the document. For example, on five of the six records we found the following was missing; the date, the patient's Mental Health Act status, reason for prescribed level of observation, risks and staff signatures had not been entered by staff. Incomplete records meant staff may be unclear as how to support the patient and also not be fully informed about the risks.

However, one patient on Larch ward had written their own guidance for staff which stated how they wanted their observations to be carried out and what their risks were. Also, observation records and management plans on the other wards were complete and had been filed in a way that meant they were easily accessible.

We saw staff often abbreviated patient whereabouts on observation records on all wards. For example 'CA' and 'BA' were entered at time intervals. However, there was no coding system in place on the document to identify what this meant. The registered manager told us they were not sure why staff were abbreviating in this way.

We were also concerned that records did not provide an accurate account of the location or presentation of the patient at the time they had been observed. We reviewed the 'Support Observations Policy 2016' at the hospital. The policy did not provide any guidance for staff in relation to completing records of patient whereabouts.

The registered manager told us there was a system in place to audit the patient records, which included reviewing these observation records. They said where issues were identified, this would be rectified. However, the registered manager told us they were not aware of the issues identified by us.

We received information of concern which stated that staff did not always administer medication at the correct times. We reviewed medication administration records for all six patients on Larch ward. We did not find any evidence to support the concerns raised. We found in three records where patients had refused medication staff had entered 'R' in the required area, but had not provided further detail on the back of the record. We asked if the prescribing staff had been notified of these issues relating to refusal of medicines. We were shown two 'multidisciplinary team sheets' which stated "to closely monitor compliance with medication" but there were no reasons recorded for the refusal of medication to enable staff, including pharmacy staff, to support the patient with their treatment.

Our review of two of the medication administration records on Larch ward also showed that for two patients who had spent time at the local acute hospital, staff had entered 'H' on their medication administration record. However, codes identified for use on the records were 'T: Take home/On leave' 'R: Refused' 'O: Other'. This meant it was not clear as to whether the medication had been administered as 'H' did not have a designated meaning on the record.

We brought this to the attention of the registered manager who told us they were not aware of these issues. They told us that an audit of medicine cards was in place and completed by an external pharmacy. However, the issues with the coding on Larch ward had not been identified.

There was a detailed safeguarding policy which included how to recognise different types of abuse and the action to take. This included the contact details of the local authority. The service had made seven safeguarding alerts between April 2016 to December 2016. Three of these had been investigated by the Local Authority the service is awaiting the outcomes. Staff on the wards knew how to raise a safeguarding concern, and the hospital recorded and responded to these appropriately, and identified lessons learnt. Staff told us they received debriefs following incidents though this was on an informal basis.

Track record on safety

The hospital reported two serious incidents requiring external investigation in the last twelve months.

Reporting incidents and learning from when things go wrong

Data we reviewed showed there had been 428 incidents reported from August 2016 to January 2017. Cedar ward had the highest number of incidents for this period with 257 incidents.

In January, staff produced an 'incident trends analysis report' covering incidents from July 2016 to December 2016. The report noted that overall there was a decline in the number of incidents over the six month period although incidents had increased during December 2016. The report noted that a disproportionate number of incidents involved a small number of patients. In December there were 79 incidents reported in total for Hazel, Maple and Cedar wards. Of the 79 incidents, 62 (78%) incidents involved the same seven patients. The report noted the trends in incidents. Of the 431 incidents from July 2016 to December 2016, 263 (61%) were incidents of self-harm.

We reviewed minutes of the local integrated governance committee meetings which took place in August 2016, November 2016, January 2017 and February 2017. For each meeting the minutes showed that incident data was

Requires improvement

Forensic inpatient/secure wards

reviewed for the previous six months, noting trends, themes and issues arising. Meeting minutes noted the action taken to reduce incidents, including the transfer of patients between wards. In these minutes it was noted that as a result of the high number of self-harm incidents, the hospital would be establishing a 'self-harm committee'. The minutes noted that a supplementary report looking specifically at themes and trends from incidents of self-harm would be produced.

Each meeting reviewed seclusion and incident data for the previous six months noting trends, themes and issues arising. In February's meeting minutes it was noted that ward environments sometimes contribute to the number of uses of seclusion as seclusion facilities offer patients a quieter space than the wards.

The hospital governance team had implemented a 'Lessons Learnt Log'. This log detailed serious incidents by month, the lessons from each incident and the action taken by the hospital to reduce the likelihood of recurrence. The log included a list of identified persons for each action and a traffic-light rating system, which rated the importance, and severity of each on-going action. This was then communicated through the hospital to staff via staff meetings and supervision.

Duty of Candour

The provider had a policy in place which provided staff with clear guidance about the different situations where they needed to be open with patients and how to support them, their families and carers, and when to provide a written apology. Staff said they followed duty of candour and ensured they initially apologised verbally and then again in writing with a full explanation. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and where appropriate a written apology.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

At the last inspection in June 2016 we rated **effective** as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are forensic inpatient/secure wards caring?

Good

At the last inspection in June 2016 we rated **caring** as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are forensic inpatient/secure wards responsive to people's needs?

(for example, to feedback?)

Good

At the last inspection in June 2016 we rated **responsive** as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are forensic inpatient/secure wards well-led?

Requires improvement

Vision and values

The hospital vision was as follows:

- 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.

Forensic inpatient/secure wards

- We exist to help people reach their individual potential, personal best and live well in their community.
- We aim to be the provider of choice for individuals with mental health needs, at every stage in their recovery journey.
- To achieve our vision we have a strong set of values.

The hospital's values were:

- Putting 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 a 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 their care and day-to-day life.
- We work directly with service users in the development of our services. Our service users added the following core values to the organisation:

- Growth
- Recovery
- Ownership
- Wellness
- Time
- Healing (& Home)
- Additionally – Hope, healing, faith, respect, support, happiness, help, willpower, family, belief.

Staff could not always identify the vision and values of the organisation, though they gave brief overarching statements which would fulfil part of the organisations mission and values. For example, "To help people recover." We asked staff how they could ensure they achieved the organisations values and objectives, all staff said they would do this as a team with effective communication and everyone pulling in the same direction. All but one staff member knew who the senior management were. All staff were complimentary about the registered manager. They said they are approachable, visited the wards regularly and attended team meetings.

Good governance

The service had a governance structure in place however, this was not robust. During our inspection, we identified a number of areas where there had been a lack of oversight by the hospital management team. This included poor standards of record keeping relating to patient care and treatment, including the observation records and medicine administration records particularly on Larch ward. The use of audit by the service had not been effective and had not identified the issues we found at this inspection with these records.

Governance systems had not been in place to identify that cleaning schedules were not being completed on Larch ward, or the gaps in the completion of the cleaning schedules on Lilac Ward and Hazel. Therefore the service could not assure themselves that the cleaning tasks were being completed.

The service had not identified a contingency plan for patients' hygiene and comfort needs in response to the ongoing boiler problems. There had been no assessment of the impact on patients within the hospital of not having access to hot water. The service had not offered alternatives for bathing and showering to ensure that patients are able to maintain their personal hygiene.

However, there were also some positives aspects in the governance of the service. The hospital had a 'local integrated governance committee' which allowed the senior leadership team to have oversight of the hospital performance. We reviewed minutes of the local integrated governance committee meetings which took place in August 2016, November 2016, January 2017 and February 2017. Meeting attendees included the hospital director, the director of nursing, the registered consultant psychiatrist, the lead occupational therapist, the involvement lead, the social work assistant and a nurse. At each meeting, incident data for the previous six months was reviewed, noting trends, themes and issues arising.

The hospital had effective systems in place to ensure that staff received mandatory training, supervision and appraisals. Whilst supervision and appraisal rates were above the hospital target, these were not based on the provider's vision and values and staff had a limited knowledge of the vision and values.

Key performance indicators were reviewed monthly in local integrated governance committee meetings. Key performance indicators were also submitted every three months to commissioners including bed occupancy, admissions, discharges, and compliance with safeguarding training.

Requires improvement

Forensic inpatient/secure wards

Patients told us they experienced differences in approaches to care between the staff that were on duty during the day, to those who worked in the hospital at night. This included the way staff spoke to them. We reported this to the registered manager who confirmed that they had concerns raised with them outside of the formal complaints process by patients very recently. The service had responded proactively and had conducted two unannounced visits to the hospital at night. The visit was attended by another staff member and consisted of spending time on each of the wards, speaking to patients and observing staff approach. The registered manager told us they had not identified any areas of concern during the visits, and patients had not raised any further concerns. They told us this method of assuring themselves that the standard of care in the hospital at night was consistent with the care on days, they would continue with the visits throughout the year.

Leadership, morale and staff engagement

There had been a recent change in the registered manager in November 2016. Most staff said the change in management had been positive and that things appear to be getting better under the new manager.

During the inspection we spoke to one social worker who was employed by an external organisation but who had patients at the hospital on her caseload. The social worker was positive about the hospital and told us that hospital staff kept her well informed about any changes related to the patients or the staff team.

There was a whistleblowing policy in place which was last reviewed in March 2016. It was not due for review again until march 2018. The policy clearly described a three stage process where staff could raise concerns to their line manager, or more senior management or to the Care Quality Commission in situations where staff could not approach senior management.

All staff told us they felt able to raise concerns without fear of victimisation. Staff felt that management at ward level was supportive as well as those at a more senior level. They felt their issues would be resolved if they approached local management such as ward managers. All staff spoke positively about their roles within the hospital and told us they felt a good sense of team work. Staff told us there were opportunities for training up to and including National Vocational Qualification level five. A staff member told us since our last inspection, six staff had commenced specialist personality disorder training.

Commitment to quality improvement and innovation

At the last inspection in June 2016 we reported that the provider should ensure they participate in national service accreditation or peer review schemes. The service had not made any improvements in relation to this at this inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- 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.

Action the provider SHOULD take to improve

- 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.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider had failed to provide the patients with hot water or alternative facilities. Observation records were incomplete and the observation documentation was not used or stored consistently. Staff were not following the policy in relation to the recording of observations to record the patient whereabouts. Staff were not following the policy when patients had refused medicines, and staff had not recorded the additional details of the refusal. This was a breach of regulation 12(1)(a)(b)(g)

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider did not have effective systems and processes to ensure that accurate records were maintained, including observation and medication records. Systems were not in place to identify that cleaning schedules were not being completed. The service had not identified a contingency plan for patients' hygiene and comfort needs in response to the ongoing boiler problems.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 17(1)(2)(a)(b) (c)