Bradley Woodlands Low Secure Hospital

Quality Report

Bradley Road
Grimsby
DN37 0AA
Tel: 01472 875800
Website: www.lighthouse-healthcare.co.uk

Date of inspection visit: 9 August 2016
Date of publication: 24/11/2016

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?	Good
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.

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.

Summary of findings

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

Overall summary

We rated Bradley Woodlands Low-secure Hospital as good because:

- The hospital had clear criteria for accepting referrals, ahead of admissions a pre-assessment was completed and reviewed by the team to ensure the provision would meet the needs of an individual.
- Following admission named nurses spent time with patients involving them in care planning within a recovery pathway. We saw examples of individualised care documents containing graphics and adapted language that made them accessible to patients.
- Individual care planning in relation to risk and staff awareness of patient's current risk levels seemed high. There was evidence that clinical risk assessments were regularly updated, live documents that contained good examples of multidisciplinary team formulations.
- Staff knew how to report incidents and there was evidence of sharing lessons learned. Over long days, all staff believed teamwork was positive, with staff pulling together for support, especially following an incident.
- Patients were encouraged to chair their own multidisciplinary team meetings using prompt cards to follow the agenda. At the meeting we attended, the patient was empowered to speak about their concerns, and given time to say what they wanted to.
- Mental capacity assessments and paperwork relating to best interest decisions used language that reflected the patient group and showed questions revisited to assess the patients' understanding and retention.
- Advocacy was available on site three days a week; staff in this service knew all the patients in the hospital and held a clear separation between their independent role and that of the hospital team.
- Visitors' rooms were private and available for patients to use to make phone calls and see visitors. Relatives described staff as being supportive and accommodating when arranging for them to visit.
- Staff were aware of key messages from management about patient centred care and positive behaviour support showed commitment to work towards this.
- Before the end of the first inspection day all emergency equipment had been checked, was in date and returned to the clinic room with signage to indicate this. A laminated list of the contents of the emergency box was available.

However,

- Emergency equipment had not been consistently stored in the places indicated by notices so any staff unfamiliar with the hospital would not know where to find it. Emergency equipment needed checking regularly to ensure it remained suitable for use, until inspection on 9 August 2016, there was no evidence this had happened since March 2016. There was no content list with the emergency equipment box, a number of items had expired and some items appeared used and unsterile. It is important items are sterile and in date when used to ensure optimum performance and to prevent infection.
- There had been a gap from March to August 2016, in the regular monitoring of fridge temperatures to ensure the safety of medicines that could not be explained. Regular clinical audits took place to monitor a range of practice, although internal and external medicines audits had been completed neither had identified medication issues found on the first day of inspection.
- The patients we spoke with told us staff were polite and most spoke to them nicely, though others did not because they shouted.
- Staffing levels were checked and reviewed by the management team and could be adjusted however,

Summary of findings

on days with only two qualified nurses staff felt under too much pressure to complete their workload. There was a mismatch on a day shift between the stated establishment of qualified nurses required and the number determined by the providers staffing ladder.

- Over three months 36% of section 17 leave was cancelled, whilst this was rearranged whenever possible, at the time of cancellation this caused distress to both patients and relatives
- Complaints made by patients were listened to and recorded by managers, however; we saw no recording of investigations having taken place. Copies of letters written in response to patients complaints were formal and it was unclear how accessible this format would be to the patient on receipt.relatives
- Systems contracted by the hospital, for example the contract to deliver physical healthcare to the patients did not always work effectively, with issues raised by staff taking some time to be resolved.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient/ secure wards	Good	

Summary of findings

Contents

Good

Bradley Woodlands Low Secure Hospital

Services we looked at
Forensic inpatient/secure wards

Summary of this inspection

Background to Bradley Woodlands Low Secure Hospital

This report describes our judgement of the quality of care provided within this location by Healthlinc Individual Care Limited known as Lighthouse Healthcare. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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

Our inspection team

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

The team included CQC inspectors and a variety of specialists:

- a CQC inspection manager
- a CQC inspector
- a nurse manager forensic services
- a specialist mental health nurse
- a CQC pharmacist.

Why we carried out this inspection

We undertook this inspection to find out whether Healthlinc Individual Care Limited had made improvements to Bradley Woodlands Low Secure Hospital since our last comprehensive inspection of the independent healthcare provider in July 2015.

When we last inspected Bradley Woodlands in July 2015, we rated the hospital as requires improvement. We rated the core service as requires improvement for Safe, requires improvement for Effective, requires improvement for Caring, requires improvement for Responsive and requires improvement for Well-led.

Following this inspection we told the provider that it must take the following actions to improve Bradley Woodlands:

- The provider must ensure that staff understand their individual responsibility in relation to the Mental Capacity Act 2005 and apply this in practice. A review of training, policy and application of the Act is required.
- The provider must ensure patients' preferences are reflected and their needs are met.
- The provide must to maintain safety do all that is reasonably practical to mitigate risks by completing work identified within a specified time.

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

- Management need to improve on the target for mandatory training of 90%; staff compliance rate at the time of the inspection was 73%.
- Replace the hand washbasin tap in the clinic room in line with current guidelines.
- Increase the range of professions within the multidisciplinary team.
- Introduce positive behavioural support for all patients in line with the department of health and the national institute for health and care excellence guidance.

Summary of this inspection

- Prioritise recruitment of registered nurses learning disability.
- Work with staff to feel safe to deliver effective care when on shift.

We issued the provider with four requirement notices. These related to:

- Regulation 9 Health and Social Care Act (Regulated Activity) Regulations 2014 Person centred care
- Regulation 10 Health and Social Care Act (Regulated Activity) Regulations 2014 Dignity and respect
- Regulation 11 Health and Social Care Act (Regulated Activity) Regulations 2014 Need for consent
- Regulation 12 Health and Social Care Act (Regulated Activity) Regulations 2014 Safe care and treatment

We reviewed the requirement notices at this inspection and found that the hospital had addressed each of them.

Plans were in place and funding agreed to ensure replacement of furniture, fittings and hinges highlighted in the ligature audit by 1 March 2017, which was the completion date agreed in the action plan.

An unannounced Mental Health Act monitoring visit to Maple ward took place on 18 July 2016. Under domain 2: Care, support and treatment in hospital, an issue was raised relating to three patients detained under the Mental Health Act being treated for a physical disorder unrelated to their mental disorder. Consent to this treatment did not appear to have been sought from these patients and no assessment of capacity to consent to this treatment had been undertaken.

The provider had submitted an action plan to ensure compliance with Chapter 13.38 of the Mental Health Act Code of Practice by October 2016. During inspection, we saw that this work was on track.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited both wards at the hospital site to look at the quality of the ward environment and to observe how staff cared for patients
- spoke with six patients who were using the service
- spoke with six carers of patients using the service
- spoke with the hospital manager and deputy manager for each of the wards
- spoke with 12 other staff members including an activities co-ordinator, two administrators, three nurses, an occupational therapist, a psychiatrist, a psychologist, a social worker and two support workers
- spoke to an external adult safeguarding social worker and an independent advocate
- attended and observed one care programme approach meeting and a multidisciplinary meeting
- attended and observed a morning meeting and an activity group involving five patients
- reviewed the Mental Health Act paperwork for four patients
- carried out a specific check of the medication management on both wards including all prescription charts and physical health records
- looked at a range of policies, procedures and other documents relating to the running of the service
- completed a detailed review of four patient records

Summary of this inspection

- reviewed three staff records of appraisal, disciplinary, supervision and training.

Information about Bradley Woodlands Low Secure Hospital

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

There are two wards: Willow provides care and treatment for female patients and Maple provides care and treatment for male patients. Both wards have separate apartments that can accommodate a maximum of four patients. At the time of our inspection, there were 18 patients at the hospital. Each patient had their own bedroom and each apartment has its own kitchen and living area. The wards are not physically separate units.

The hospital had a registered manager and they were the controlled drugs accountable officer.

What people who use the service say

We spoke with six patients and six relatives of patients.

Patients told us they had been involved in planning their care and supported by staff to do this. Patients said most staff showed them respect and that they could talk to staff if they became upset. One patient described restraint as being calm when it happens. Relatives described staff as respectful and polite. They found staff to be caring and supportive of patients.

Patients liked having their own room with their own things in the apartment. Patients seemed happy to share their apartment with others. Relatives commented the importance of patients having their personal belongings with them. One patient became upset when the alarm sounded, saying they hated all the noise in the hospital.

Patients described having their rights read and explained to them regularly. The patients we spoke to all knew the advocate was available and that they could see them if they wished to. Patients would complain to the manager, the advocate or their relative. Relatives said they would complain, if needed, to management or the doctor in charge.

Patients told us they had a choice of activities, though there were fewer provided at the weekend. There was some frustration expressed by patients when changes were made to planned activities. Some relatives expressed concerns about cancelled activities; others believed there were always things for patients to do within the hospital.

Patients enjoyed going out of hospital into the community, however those near discharge felt once a week was not often enough. Relatives with a patient working towards discharge felt that planned visits home were not regular enough. Relatives of three patients spoke positively about staff facilitating patient visits home. However, we heard of two recent examples of home visits cancelled at the last minute. Both were re-arranged, but this was described as be very hard for the patients and their relatives at the time.

Patients and relatives described being a long way, geographically, from each other as difficult. Arrangements to speak on the telephone were individually care planned and appeared to work well. Staff were described as being both supportive and accommodating when arranging for relatives to visit. Although we were told it had been difficult over the Christmas period 2015 when there was limited use of the visitors' rooms due to the hospital facilitating Care and Treatment Reviews with NHS England. Two relatives saw this as inappropriate given the time of year.

Summary of this inspection

Relatives were invited to care programme approach meetings, received information ahead of these meetings and minutes afterwards. They felt listened to by staff within these meetings and had their questions answered. Relatives described good clear communication with doctors and nurses in this forum. Communication from the hospital to relatives included regular written reports. However, relatives did not always feel well informed outside of meetings. They had concerns that some care workers seemed to know little about specific decisions or agreements previously made. This led to times when what was or was not allowed was not always consistent or linked to care planning. Relatives described variations, depending on who was on duty, as making a difference to the mood of patients.

Relatives with patients who had been within the service for some time described the care and treatment delivered as becoming clearer to them. They believed a lot goes into ensuring patients at Bradley Woodlands remain safe. Two families described the hospital as the best service their relative has received. This has led to some concerns when there is talk at meetings of discharge. Most relatives were concerned that suitable placements for patients with complex needs seemed very limited.

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 had been a gap from March to August 2016, in the regular monitoring of fridge temperatures to ensure the safety of medicines.
- Emergency equipment needed checking regularly to ensure it remained suitable for use, until inspection on 9 August 2016, there was no evidence this had happened since March 2016.
- Emergency equipment had not been consistently stored in the places indicated by notices so any staff unfamiliar with the hospital would not know where to find it.
- There was no content list with the emergency equipment box, a number of items had expired and some items appeared used and unsterile. It is important items are sterile and in date when used to ensure optimum performance and to prevent infection.
- There was a mismatch on a day shift between the stated establishment of qualified nurses required and the number determined by the providers staffing ladder. Staff told us they felt under pressure when during the day there were two, rather than three, qualified nurses on duty.
- Over three months 36% of section 17 leave was cancelled, whilst this was rearranged whenever possible,

However,

- The ward was clean, there were separate male and female apartments with a kitchen lounge, dining area and individual en suite bathrooms and every patient had their own bedroom with an en suite bathroom.
- Individual care planning in relation to risk and staff awareness of patient's current risk levels seemed high. There was evidence that clinical risk assessment were regularly updated live documents that contained good examples of multidisciplinary team formulations.
- Staff knew how to report incidents and there was evidence of sharing lessons learned.
- Over long days, all staff believed teamwork was positive, with staff pulling together for support, especially following an incident. .
- Staff and managers saw safeguarding as everyone's responsibility, training was in place and concerns were reported to external agencies.
- Compliance with the core mandatory training modules met the provider's target.

Summary of this inspection

Are services effective?

Good

We rated effective as good because:

- Robust pre-admission and admission assessments identified the specific needs of patients.
- Staff involved patients in planning and reviewing their care, using graphics and adapted language to make documents more accessible.
- Patients were encouraged and supported to chair their own multidisciplinary team meeting using prompt cards to follow the agenda.
- The aim of the multidisciplinary team was to offer person centred care that met patients' individual therapeutic needs. Team members spoke of working collaboratively with the patient at the centre and respecting each other's views.
- Multidisciplinary formulations, from carefully considered information supported the historical clinical risk assessments.
- The systems in place ensured staff complied with the Mental Health Act, staff informed patients of their rights regularly, verbally and through written and pictorial formats.
- Staff showed understanding and were clear about their individual responsibilities under the Mental Capacity Act 2005.
- Staff told us mandatory training, supervision and appraisal made a positive difference to practice.

However,

- The internal and external medicine audits in place to ensure effective clinical practice had not been robust.
- Staff had raised concerns for some time that access to physical healthcare treatment for some patients was not effective before managers had received assurances from the contracted providers this would change.

Are services caring?

Good

We rated caring as good because:

- Patients liked having an own en suite room with their own belongings in their apartment.
- Relatives commented positively about the importance of patients having personal belongings with them.
- Individual patients knew their key worker, the names of care staff and the hospital managers and said they could talk to them.
- Person centred approaches increased patients involvement in planning their care.
- Support staff caring for patients understood the individual needs of the patients in their apartment.

Summary of this inspection

- Patients told us they had a choice of activities, and individual activity timetables showed this.
- Staff in the independent advocacy service represented all the patients in the hospital.
- A weekly involvement forum attended by patients, staff and managers encouraged feedback and discussion on any changes within the service.
- Patients had acted as representatives at wider network meetings on behalf of their peers.

However,

- The patients we spoke with told us staff were polite and most spoke nicely, though others did not because they shouted.
- Patients' expressed frustration when changes and cancellations were made to planned activities.
- Patients were concerned that community meetings, which they valued, had not been held as regularly in recent months whilst managers had been off.

Are services responsive?

Good

We rated responsive as good because:

- The hospital had clear criteria for accepting referrals, ahead of admissions a pre-assessment was completed and reviewed by the team to ensure the provision would meet the needs of an individual.
- For each patient we saw a referral, admission and discharge progression pathway document in use that considered the future needs of each patient on discharge from hospital.
- There was a wide range of facilities and amenities within the hospital. Patients told us they had a choice of activities, and individual activity timetables showed this.
- Patients' rooms were personalised and ahead of the planned refurbishment within the hospital, patients had been involved in making choices about colour schemes.
- Easy read text and pictorial leaflets about aspects of care were available. We saw examples of individualised care documents containing graphics and adapted language that made them accessible to patients.
- Visitors' rooms were private and available for patients to use to make phone calls and see visitors. Relatives described staff as being supportive and accommodating when arranging for them to visit.

However,

- Doors on self-closing hinges banged shut frequently in the ward environment.

Summary of this inspection

- Some of the furnishings looked in need of replacement and décor in the apartments was tired, work to resolve this was planned with a completion date of March 2017.
- Patients' expressed frustration when changes were made to planned activities.
- Complaints made by patients were listened to and recorded by managers however; we saw no recording of any investigation having taken place.
- Copies of letters written in response to patients complaints were formal in nature and it was unclear how accessible this format would be to the patient on receipt.

Are services well-led?

Good

We rated well-led as good because:

- Staff were aware of key messages from management about patient centred care and positive behaviour support showed commitment to work towards this.
- Staff reported incidents appropriately and received feedback individually and through supervision.
- Regular clinical audits took place; from these we saw action plans and changes that improved practice.
- The hospital was involved in local and national forums that included sharing information and reviewing practice.
- However,
- Staffing levels were checked and reviewed by the management team and could be adjusted however, on days with only two qualified nurses staff felt under too much pressure to complete their workload.
- Neither the internal nor the external medicines audits completed had identified the issues found on the first day of inspection.
- Staff meetings were available however; due to the demands of the hospital, the majority of staff were not able to attend.

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.

The use of the Mental Health Act 1983 was appropriate; detention documentation complied with the Mental Health Act code of practice. The provider had a Mental Health Act administrator who completed audits and scrutinised documentation. For individual patients the system in place flagged important dates, which included: tribunals, renewals of detention and deadlines for reports. The administrator ensured patients and staff were aware of these timescales.

Staff informed patients of their rights verbally and through written and pictorial formats. Patients who were able to understand their rights confirmed to us that staff regularly discussed these with them. We saw evidence on the database that recorded that patients were informed of their rights in relation to the Mental Health Act. This included documentation of the frequency of conversations along with the staff member completing the review and the outcome or patient's level of understanding the discussion.

The provider had a contract with an independent mental health advocacy service. All patients were able to access this. Four patients told us they could go to the advocate if they had a problem. Patients who were unable to ask for an advocate were on a watching brief, this was where an advocate made sure each patient was seen at regular intervals. We saw attendance by the advocacy service at relevant meetings.

Ninety one percent of clinical staff had received mandatory training in the Mental Health Act. We reviewed the content of this training, which included the 2015 amendments to the Code of Practice and the guiding principles.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had good knowledge of the mental capacity assessment process and the basic five principles in relation to the Mental Capacity Act 2005. Staff mandatory training, which had been updated in November 2015, showed ninety-one per cent compliance. Following induction, specific update training included a test for attendees to check staff understanding of their learning. We reviewed the content of the training, which focussed on the practical application of the law in relation to the patient group of the hospital.

In addition to care programme approach meetings and care and treatment reviews, which involved relatives, capacity was part of the set agenda for each patient at their multi-disciplinary team meetings. Deprivation of liberty safeguards were not required because all the patients at Bradley Woodlands were detained, staff understood this and staff told us they followed the principles least restrictive practice when delivering care. Staff described decisions made in a patient's best interests as considering what needed to happen from the perspective of what a patient would want based on the knowledge and understanding they had of this.

Formal Mental Capacity Act documentation was present and appropriate. We saw capacity assessments and paperwork relating to best interest decisions. There was evidence of the questions asked and patients' responses to questions from Mental Capacity Act assessments. The language used was accessible for individual patients. Questions asked were revisited to assess the patients' understanding and retention. We saw an example of a finance assessment completed by the social worker using graphics and adapted material.

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

The two wards, Willow (female) and Maple (male), consisted of separate apartments built around a central secure courtyard. The wards were not physically separate units. Gender specific apartments were next to each other. Within individual apartments, every patient had his or her own bedroom. All rooms had en suite bathroom facilities. Each apartment had its own lounge, kitchen and dining area. This complied with the Department of Health eliminating mixed sex accommodation guidance.

There were separate rooms within the apartments that meant that patients were not always in the immediate line of sight of staff. However, the layout of the apartments resembled more independent living settings similar to a small shared flat, aided rehabilitation. At least one member of staff was on duty in each apartment at all times. If needed, there was enough space within the apartments to carry out restraint safely. All staff had access to personal alarms and carried radios to request assistance if needed. An alarm system linked the apartments to the nurse's station. If the alarm raised this was active across the whole site. There was a designated response team on each shift. In addition to this, whilst on site we saw managers and members of the multidisciplinary team respond to alarms.

During the first day of inspection, the ward was very busy with a number of alarms activated. There appeared to be a problem with the ward alarm system. In one instance, it took over five minutes to silence the alarm. In addition, some of the ward radios did not appear to be working effectively.

A staff member used the telephone in the apartment to call the ward office to request assistance; it had not been possible to use the other systems to make this request. They had been alone in an apartment and due to the lack of timely response had begun to feel vulnerable. Once support from others did arrive, we saw the emerging difficulties dealt with effectively. The ward teams appeared supportive of each other when under stress. We witnessed a support worker being debriefed and supported in the ward office following an incident.

We asked the registered manager about the systems in place to ensure the alarms were working effectively and radios charged. There had been no reported fault with the alarm system and an immediate request to maintenance to check this was made. We saw a clear system for signing in, charging and signing out radios at reception on a daily basis. It was not clear if the radios not working effectively had a fault or had not been fully charged, but we were assured they would all be checked.

A completed ligature risk audit from April 2016 identified fixtures and fittings within the apartments from which an item could be tied on in order to attempt hanging. Refurbishment and re-decoration of the apartments was underway, this included replacement of these fixtures and fittings. An order for new anti-ligature bedroom furniture and updated kitchens had been placed. This work was due for completion by March 2017. We saw a specific action plan monitored in clinical governance meetings that identified physical changes to be made and progress towards these.

Good

Forensic inpatient/secure wards

We observed that staff within the ward areas supervised the patients most of the time. Individual care planning in relation to risk and staff awareness of individual patient's risk levels seemed high. Staff would escalate concerns and request additional support should a patient seem at increased risk of wanting to harm him or herself.

Two ligature cutters were in a clearly marked box on the wall in the nursing office. All staff on the ward had a key to access the office door. There had been no external sign to indicate that the cutters were kept in the office, which could have been difficult for staff unfamiliar with the hospital however, new signage was put up during the inspection. There was a log indicating when and for whom the cutters were last used.

The nurse in charge and the staff nurse for each ward held keys and shared responsibility for the clinic room. The clinic room was clean and tidy with all soap dispensers and hand wash dispensers full. Sharp bins were empty and clean. The tap in the clinic had been replaced with mixer tap as indicated in the previous inspection. No trip hazards present. However, the clinic cleaning rota was last completed on 7 March 2016.

The controlled drugs cupboard was locked and secured to the wall. All entries signed and dated by two staff nurses and the register signed by a pharmacist. Both drug trollies were locked to the wall and secure. Each trolley consisted of a number of individual draws containing patients named medication. However, there was an inconsistency in labelling with some draws not labelled with the patients' name, date of birth and hospital number to cross check with the prescription charts.

On the first day of inspection, there were 19 pairs of sterile scissors in an unlocked clinic room draw. There was not a checklist in respect of these. There were three pairs of scissors, one set of nail cutters and forceps in an unlocked draw, also with no checklist. Before the end of the inspection, the whereabouts of all scissors and cutters being kept could be identified within a checklist.

During our inspection, we saw that fridge temperatures were last checked on 24 March 2016. This entry noted two thermometers were not working; these were not working on the first inspection day. Before the end of the inspection period, a new fridge temperature thermometer was in place with staff were recording temperatures daily. The temperatures recorded were slightly higher than the recommended range. Staff had identified this, contacted the supplying pharmacy to request a replacement fridge, and asked for advice to check the medicines within the fridge were suitable to use. The quarterly medicines audits had not identified this issue, however, we were assured that going forward checks would be monitored and picked up within this regular audit.

The oxygen checklist had last been completed 26 March 2016. We found the oxygen kept in the ward office contrary to the notice on the clinic room door stating it was there. The emergency equipment box was in the ward office with no external notice to indicate this. There was no content list with the box, a number of items in the box had expired and some items appeared used and unsterile. It is important items are sterile and in date when used to ensure optimum performance and to prevent infection. The lack of a contents list for an emergency box makes it difficult to confirm if all the equipment that may be needed in an emergency is available. The heart start defibrillator was also in the ward office with no external notice to indicate this; was last checked on the 4 June 2016.Its bag contained a pair of scissors. There was no checklist for these. Emergency equipment needs to be checked regularly to ensure it remains suitable and ready for use in an emergency.

Before the end of this inspection day the oxygen had been checked, was returned to the clinic room and the clinic room was sign posted to show the oxygen was there. The emergency box and defibrillator had also been checked returned to the clinic room, with appropriate signage. A laminated list of the contents of the emergency box was available. Expired items had been disposed of and all emergency equipment was in date.

Managers had introduced a daily check sheet for night staff to check the emergency equipment.

During our inspection, we saw the daily check completed from initiation on 10 August 2016 and a memo sent to all staff nurses from the registered manager indicating their responsibility in relation to this duty.

The provider reported all staff had received immediate life support training that included defibrillation on induction. Annual updates that were mandatory showed 90% staff compliance.

The hospital completed refurbishment of its seclusion suite in 2015. The room allowed clear observation, with blind

spots mitigated by fish eye mirrors. A two-way communication device was in place. The seclusion room was clean and tidy with a clock, strong mattress and blankets. Toilet and washing facilities were available. A small kitchen to make drinks and snacks was part of this suite.

All ward areas appeared clean and tidy however, furnishings and decoration were ready to be refreshed. Patients and staff had been involved in choices relating to the on going refurbishment programme. The balance between rooms being homely and ligature-free was a consideration for those patients preparing to leave hospital. Decisions about personal items and televisions and radios in patients' rooms being boxed in for safety (or not) had been made based on individual risk assessments.

Patients could access the courtyard with permission from staff, who checked with each other to ensure the mix of patients was safe. During the inspection, some patients and staff were outside sitting at tables chatting.

The cleaning roster completed for each 24-hour period covered all areas of living accommodation that required cleaning was up to date. Staff told us a deep clean by an external contractor had taken place recently. In three apartments, we saw monitoring of fridge and hot water temperatures, all were within normal limits and showed no gaps. In addition, the hospital employed two housekeepers to ensure all areas provide high standards of cleanliness.

Infection control was part of induction and annual update training was mandatory training for all clinical staff. The provider training figures showed 90% compliance. Staff spoke to us about the importance of infection control, including hand washing. We did not see any specific hand washing assessments.

Throughout the hospital, electrical items showed evidence of portable appliance testing. The hospital employed a team of maintenance staff to meet the daily maintenance, repairs and replacements. There was also a gardener to maintain extensive grounds.

In addition to generic environmental risk assessments, the provider had undertaken the ligature risk audit; a seclusion room risk assessment; new flooring risk assessment in main hospital corridor and a smoking cessation risk assessment in the last twelve months.

Safe staffing

Establishment levels: qualified nurses (WTE) 12 (made up of 14 nurses)

Establishment levels: support workers (WTE) 62 (made up of 66 support workers)

Number of vacancies: qualified nurses (WTE) one (two additional nurses had been recruited and were awaiting PIN numbers)

Number of vacancies: support workers (WTE) four (seven under offer at the time of the inspection).

The registrations of the nurses employed:

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

There was always at least one registered nurse learning disability or registered nurse mental health on each shift. Due to local difficulties in recruitment, there were not enough registered nurse learning disability nurses employed to have one on every shift.

The lead nurse or deputy manager checked and reviewed staffing levels across each 24-hour period and adjusted these according to need. Staffing rotas confirmed an increase in staff was possible, and occurred to accommodate specific needs for example, if observation levels were increased. Additional resource came from overtime, bank or agency staff. When possible, nurses and support workers worked overtime to cover additional shifts, this was monitored by the lead nurse or deputy manager to ensure that staff did not work excessive hours each week. Bank staff who knew the patients were requested in preference of agency staff. If required, the same agency staff, who had completed an onsite induction, were asked to offer as much consistency as was possible to patients.

The length of day shifts was 12.5 hours; night shifts 12 hours. We were told staff had two break times of 20 minutes on each shift allocated in accordance with the working time directives. Breaks were set within the shift for staff by the nurse in charge. Whilst breaks needed to be managed effectively to ensure safety in the hospital, staff were encouraged to take their breaks. Most qualified staff took their breaks within the ward office so they remained

available; those who left the office took radios with them so they could respond to an incident. We saw support staff given additional time away from duties following involvement in an incident.

For the three months of May, June and July 2016 the total shifts required to cover the hospital over 24 hours was 2856. Of these 2180 (76%) were covered by staff on rota to do so. Leaving 676 (24%) of shifts requiring cover. Of these shifts the current workforce filled 403, bank staff filled 182 and agency staff 55. Leaving 33-day shifts and three night shifts it had not been possible to fill, these were all shifts where little prior notice had been given for example, staff reporting sick.

Information from the provider stated the establishment for the hospital was a minimum of two nurses per shift day and night with additional nurses on duty to cover the needs of the service. For example, when there were specific meetings, such as multidisciplinary team, care programme approach or a care and treatment review more nurses were on the rota during the daytime, so they are able to attend. These shifts were not identified on the staffing rotas we reviewed.

The provider's staffing ladder to determine the staffing levels linked to the individual needs presented by each patient and their NHS England contract. The staffing ladder indicated that for 18 patients, three qualified nurses and 15 support workers were required during the day and two qualified nurses and 15 support workers at night. There was a mismatch between the required number of qualified nurses on a day shift between the staffing ladder and the establishment.

Staff told us they felt under pressure when during the day there were two, rather than three, qualified nurses on duty. However, over long days, all staff believed teamwork was positive, with staff pulling together for support, especially following an incident.

Staff sickness rate in the 12-month period 1 August 2015 to 31July 2016 was qualified nurses 3%, support workers 5% however; this did not include staff off for work related injury or long term sickness.

There had been absences, some planned, and others unexpected of the registered manager, deputy manager and lead nurse at different times from the end of May until July 2016. These individuals formed the core of the small management team at the hospital.

We saw communication memos to staff with rotas attached that indicated staff had access to daily management support. Managers known to staff locally and from the wider organisation provided this. In addition, staff had access to on-call managers throughout every 24-hour period. Whilst it was clear that management cover had been in place, staff felt the absence of the managers they knew well.

Over this time to offer additional support to staff, the role of the nurse in charge was also extended. At times, this had meant one to one time for patients with their named nurse had not always happened.

Staff turnover rate in the 12 month period 1 August 2015 to 31 July 2016

Qualified nurses 50.3% (which was seven nurses), support workers 23.3%

Exit interviews had been carried out with all staff, there were no common themes. Reasons given included moving on for higher pay; retirement; personal circumstances; transfers within the organisation; to undertake further development/ nurse training and staff dismissal. One member of nursing staff who left to widen their experience had recently returned to this provider.

In the three-month period May to July 2016, 196 out of 542 (36%) section 17 leave were cancelled however, the manager told us that wherever possible this was rearranged as soon as is practicable and should be considered postponed rather than cancelled. Despite this assurance we saw no figures to support this.

Resource issues recorded for cancelled leave included: leave retracted for safety reasons where an individual risk assessment indicated leave might not be safe to be facilitated for the patient; or risks within the hospital meant staff needed to remain on site to ensure safety; hospital transport repairs and poor weather conditions.

Two out of three relatives who commented told us that when leave involving them had been cancelled it was usually rearranged as soon as was possible. However, at the time cancellation caused distress to both patients and themselves. The other relative said in their experience, it was rare for cancelled leave to be rearranged. Two patients commented being upset when their leave was cancelled because of lack of staff.

Good

Forensic inpatient/secure wards

The activity coordinators and the occupational therapist, none of whom had any absences, facilitated the majority of internal activities with the assistance of support workers. We were told that no activities provided within the hospital or grounds had been cancelled in the three-month period May to July 2016.

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

In an emergency, if the psychiatrist was not on site, the hospital had a service level agreement with a local general practitioner practice; staff had also used the 111 number for advice, contacted emergency services, or taken the patient to the accident and emergency department at a local National Health Service trust close by.

We identified the hospital target for mandatory training had reduced from 90% in 2015, to 80%. However, we found that staff compliance rates for mandatory training and updates was 90%.

This excluded staff induction, which we were told all staff received. Recorded rates from 2007 to date, showed 73% completion. The explanation given was that 27% of staff completed their induction prior to the current training recording system. However, none of these staff showed as attending the hospital's induction refresher.

In addition to the nine core modules for all staff, nurses and support workers were required to complete food hygiene every three years, compliance 75%.

Medication management showed on the training schedule as required mandatory training for registered nurses however, of the 14 nurses only 50% had completed this.

Assessing and managing risk to patients and staff

Seclusion is the supervised confinement of a patient in a room, which may be locked, to contain severely disturbed behaviour that is likely to cause harm. There were five episodes of seclusion in the six months prior to inspection. Two took place on the same day and none lasted longer than 10 minutes. No long-term segregation had taken place in this period.

The provider regarded all 'hands on' contact as physical interventions and restraint, and records this accordingly**.** There were 334 incidents of physical interventions, including redirection, guiding, holding, restrictive holds in the six months prior to inspection. There was one incident of restraint where a patient was in the prone position.

Staff had not administered rapid tranquilisation in the six months prior to inspection. The provider had a policy offering clear guidance to staff that included assessment of the patient/situation and risk. The policy dated February 2013, was under review by the providers governance committee.

Restraint was used after de-escalation had failed. The staff we spoke to were committed to talking to patients or changing something in their environment to help them calm when stressed. A patient described restraint as being calm when it happened. Staff could give a definition of restraint and knew how to report it. A manager reviewed all reported incidents. Debrief was offered to patients and staff involved in any incident of restraint.

We completed a detailed review of four patient records chosen at random. We had access to the electronic and paper file records. There were examples of comprehensive historical clinical risk assessment tools with formulation. There was evidence that these were live documents, updated regularly to reflect clinical/current risk factors. Examples of multidisciplinary team formulations supported risk assessments. In addition, some patients had a manual handling risk assessment. All staff present appeared to understand the specific risk factors in relation to individual patients.

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

Good

Forensic inpatient/secure wards

Following a pre-admission assessment, which included risk screening, the senior management team had the option to refuse patients referred for admission who posed a high risk to staff and/or other patients referred at Bradley Woodlands.

The hospital was a low secure facility, with the necessary level of security. All patients were detained, with leave planned and agreed. Male and female patients could mix with staff supervision as they moved around the hospital. We saw fully completed logs for individual patients on different levels of observation.

During the first day of our inspection, we found people were not protected against the risk associated with the unsafe management of medicines. We found that medicines were not stored appropriately and emergency medicines and equipment had not been recently checked; some emergency medicines were found to be out of date. The hospital manager undertook to make immediate changes to address our concerns. When our specialist pharmacist visited on the second day of the inspection, we found that improvements had been made to all areas of concern that we had raised. There were now appropriate arrangements for the management of medicines.

There was a process in place to manage the safe ordering, storage and disposal of medicines. Medicines were stored securely in locked treatment rooms and the keys held by the nurse in charge. All expired or unwanted medicines were in appropriate pharmaceutical waste bins, and disposed of according to current legislation. The nurses checked the medicines stock levels each week to ensure the correct doses were administered and the hospital held adequate supplies in stock.

On the first day of the inspection, we found that fridge temperatures had not been monitored for some time, on our return we saw that staff had checked the fridge temperatures and clinic room temperatures daily to ensure the safe storage of medicines. Where the fridge temperature was not within the recommended range of 2 to 8 Celsius this had been discussed with the supplying pharmacy to confirm medicines were still safe to use. Staff had also checked emergency equipment and medicines on a daily basis to check they were in date and safe to use, logs confirmed this. New supplies had been obtained to replace out of date medicines.

We found links between the service and the supplying pharmacy. External pharmacy audits of medicines at the hospital were carried out quarterly in addition to internal medicines audits. We saw actions had been completed from a recent audit carried out by the external pharmacist. However, this audit had not identified the issues with medicines we found on our visit.

As part of this inspection, we looked at the medicine administration records for all patients. Appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were being administered their medicines at the right time and any reasons for not giving people their medicines were recorded.

Where medicines were prescribed to be given 'as and when required' or where they were to be used only under specific circumstances, there were individual "when required" protocols, (administration guidance to inform staff about when these medicines should and should not be given). They provided enough information to enable staff to make decisions as to when to give these medicines to ensure people were given their medicines when they need them and in way that was both safe and consistent.

Medicines were prescribed by a combination of the in-house medical team and a contracted primary care provider. We saw instances where there had been delays in obtaining medical advice, appointments, blood test results and medicines when prescribed by the primary care provider. Staff told us they had identified problems with some aspects of the contracted service and we saw meeting minutes and action plans to show this was being addressed.

All certificates of consent to treatment T2 and confirmation of authorised medication certificate of second opinion T3 forms for detained patients were in place. The service had a rapid tranquilisation policy, and we saw where medicines had been administered for this purpose appropriate documentation had been completed.

Staff compliance with safeguarding training was 90% the staff we spoke with could recognise a safeguarding concern and this would be reported to the management team. At the morning meeting, safeguarding was a standing agenda item. If a concern arose, the actions required and who would fulfil these in terms of reporting was identified.

Good

Forensic inpatient/secure wards

Senior managers spoke of good relationships with the local authority safeguarding team who they could turn to for advice and support if needed. North East Lincolnshire adult safeguarding team confirmed they had good communication with this provider around both referrals and queries. It was their belief that duties to safeguard patients at Bradley Woodlands were undertaken conscientiously.

The responsiveness of Humberside police when they needed to interview patients following significant safeguarding disclosures was causing concern to both the hospital and the local safeguarding team at the time of our inspection. The hospital manager had plans to raise this with the police authority.

The hospital had two visitors' rooms near reception. We heard an example from carers of the staff accommodating the visit of a child to their uncle. Sensitivity and careful planning ensured the safety of all concerned.

Track record on safety

In the last 12 months, the hospital reported six serious incidents to NHS England,..

Senior management and the multidisciplinary team reviewed serious incidents. These were discussed at clinical governance, hospital planning and executive team meetings. Post-serious incident reviews considered lessons learned and how these would be communicated to staff.

Adverse incidents in the last six months included three staff suspensions following incidents. In each case, the provider notified the care quality commission . Three staff had sustained injuries, requiring attendance at the general hospital.

Reporting incidents and learning from when things go wrong

The staff we spoke to understood the need to report incidents and knew how to do so in the hospital systems. Staff used an electronic incident recording system and daily care notes to record incidents, these systems linked to each other and could be read by all staff.

Specific incidents were reviewed in the weekday morning meeting by the multidisciplinary team; this morning meeting, promoted communication between the wards, multidisciplinary team and senior managers. The meeting covered staffing levels, incidents, and queries from patients brought by managers. It was clear the staff involved in this meeting knew the patients well. Minutes of the meeting were emailed to team members unable to attend.

Reviews of incidents also took place within multidisciplinary team meetings, care programme approach meetings and care and treatment reviews for individual patients. Whilst nurses felt part of this, support workers did not. It was difficult within this low secure environment to hold a team de-brief. Staff received feedback following incidents primarily through individual debrief. Support was also available through planned and ad hoc supervision from colleagues, and members of the management team.

Other reviewing processes the hospital used included incident analysis meetings; serious incident reviews; clinical governance; health and safety meetings; post serious incident reviews; hospital planning meetings and executive team meetings. Minutes from these meetings were available to staff. We reviewed minutes of clinical governance and hospital planning meetings and saw the recording of incidents reviewed.

Staff were aware of their responsibilities both to report incidents and to be open and transparent with patients if something goes wrong. Following a breach of confidentiality, we saw the provider had been open with both the patient and their relative about this. We also saw that lessons learned from this incident shared with staff.

Learning from incidents in the last six months had included more regular fire drills and siren testing to reduce patient's anxieties when this happened. Additional first aid training delivered to staff had improved their reporting. Advice obtained from the conflict management trainer regarding techniques in respect specific patients resulted in staff learning and adapting their approaches.

Recent improvements in safety have included:

- The re-design and completion of the seclusion facility
- The removal of stones and some plants from the secure garden
- New robust dining room furniture and bedroom furniture to low secure specification ordered

New guidelines in place for patients regarding use of electronic-vapours for unescorted and escorted leave.

Good

Forensic inpatient/secure wards

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Following a pre-admission assessment, which included risk screening, informed a multi-disciplinary team discussion about the suitability of the placement. If the patient was accepted, an initial care plan was created. Once the patient arrived at the hospital, baseline assessments were on going for their first twelve weeks.

With the assistance of a staff member to gain access to the electronic patient file records in addition to other specific paper based information we reviewed four care records in depth.

Patients' records had thorough examples of positive behavioural support plans, with evidence of patient involvement in the formulation of these. These were within the 'A files' kept in the apartments to allow staff to use this information to underpin interaction with patients. However, patients did not always sign the positive behavioural support plans.

There was evidence of holistic care plans in a range of areas including mental health, physical health, recovery and risk. All showed evidence of review. However, some plans due for renewal were past their identified renewal dates.

There was evidence of person centered plans which contained strengths and weaknesses identified by patients along with aspirations for their future. Some patients had visual person centered plans. All plans contained signs and graphics to assist in understanding and supported written information. Individual patients had chosen the graphics used within their plan. Some plans contained information representing knowledge of the patients' likes and dislikes.

We saw examples of communication passports containing graphics and adapted language making them accessible to patients. However, the box on the front of the electronic file documenting that the care plan had been given to the patient was not consistently completed and patients did not always sign care plans. The patients' comments box was not consistently completed. There was evidence that patients had engaged in their care and treatment review.

There were good examples of discharge pathway documentation with formulations and future placement options identified. Staff informed us that some patients had visual discharge pathways. The plan was that all patients would have a visual discharge pathway in the future.

The database to record the informing of rights in relation to sections of the Mental Health Act showed the frequency of conversations, the person completing the review and the outcome/level of understanding what was said.

There was evidence of attendance at optician, dentist and specific external healthcare appointments in patient records. Physical healthcare was provided by a local general practitioner service, who visited the hospital weekly, though some patients were able to attend the surgery. However, the patients' physical health records were not accessible to ward staff. There was no formal record of physical examination on admission, or of patients' yearly physical health check. The hospital manager assured us that these had been completed and was exploring ways to capture the physical health data on the hospitals electronic system. During the inspection, a meeting took place with the physical healthcare provider to progress this.

The systems in use were both electronic and paper based, staff knew where and how to access the information they required. Staff stored patient's main files securely in the nursing office with individuals care plans available in the apartments.

Best practice in treatment and care

The consultant psychiatrist followed the National Institute for Health and Care Excellence guidance when prescribing and reviewing medication. National Institute for Health and Care Excellence guidance was referenced within medication policies, including the administration of medicine.

The aim of the multidisciplinary team was to offer person centered care that met patients' individual therapeutic needs. The person centered plans contained strengths and weaknesses identified by patients, along with aspirations

for their future supported this work. We heard from the occupational therapist about a move away from patients joining the activities on offer to the delivery of activity and therapy to meet individualised choices and needs.

The positive behaviour support plans we saw showed evidence of patient involvement. We saw examples of some communication passports containing graphics and adapted language. Multidisciplinary formulations, from carefully considered information supported the historical clinical risk assessments.

Staff completed health of the nation outcome scales on admission and repeated this as an outcome measure for each patient. In addition specific pre and post intervention assessments were used depending on the needs of individual patients, for example, cognitive behavioural therapy; dialectical behaviour therapy and sex offender treatment readiness. Nurses spoke of incorporating specific information and knowledge from different disciplines into patients' overall care.

All patients had a physical healthcare care plan and their weight; blood pressure and pulse checked and recorded weekly. One of the aims of the meal planning completed within apartments was to ensure patients' individual nutrition and hydration needs were met.

All patients were registered with a local general practice surgery, which provided sessions within the hospital. We were told that annual health checks had all been completed in January 2016 however, at the time of inspection the records of these were with the general practitioners electronic system.

There was evidence in patient records of attendance at optician, dentist and specific external healthcare appointments. In addition to individual appointments and clinics run by physical healthcare practitioners, groups with a focus on physical health care had been held within the hospital. These included separate men and women's health groups; a diet and exercise group; a women's hygiene group and a smoking cessation group.

Clinical audits lead by the deputy manager took place on a quarterly rolling programme with the support of clinicians. These included records and documents; security and safety; handover; medication management systems; healthcare records; observation; cleanliness and infection; staffing; mental health documentation; section 17 leave; medicines audit. We reviewed the most recent audits for medication management; records and documents; observation; handover; staffing and observation levels. Each audit was scored; where scores fell beneath 100% we saw action plans with review dates to monitor practice improvements. Whilst regular clinical audits took place, the medicines management audit had not been broad enough picked up the issues we identified on inspection.

Skilled staff to deliver care

In addition to qualified nurses and support workers, who provided 24-hour care at Bradley Woodlands the composition of the wider multi-disciplinary team included:

- 0.8 consultant psychiatrist
- 0.5 consultant psychologist
- One trainee forensic psychologist
- Two assistant psychologists (vacancy for an additional psychology assistant at shortlisting phase at the time of the inspection with interviews planned for September 2016)
- 0.5 occupational therapist
- Two activity coordinators
- 0.8 social worker
- 0.5 speech and language therapist.

This was a significant increase in the range of professions within the multidisciplinary team since the last inspection. Services accessed from external providers as required included dietician; dentist; podiatrist; optician, pharmacist and aroma therapist as required.

We reviewed the induction programme for staff, which included mandatory training and orientation to the hospital. Following this, staff remained additional on the rota to allow them time to get to know patients, colleagues and systems. Support workers, completed the Care Certificate package as part of their induction and probationary period. In addition, the training department supported national vocational qualifications in health and social care, and access to the diploma in health and social care.

The registrations of all clinical staff were in date. This was monitored through the provider's payroll database and senior administrator's staff database.

The provider's policy had a minimum standard that all staff received supervision that included both management and clinical aspects no less than quarterly that was being met. Managers identified themes each quarter for staff to explore in clinical supervision, their understanding was then analysed on a quarterly basis.

The service was working towards increasing the support to all clinical staff engaging directly with patients delivering clinical activities and support, to monthly supervision as stated in low secure standards. Some staff received supervision more frequently dependant on need. We were told variations made according to need could mean that supervision might be daily, weekly or monthly, all of which was recorded. Over the summer when staff had felt under increased pressure, some individual supervision sessions had not happened when due. Staff showed a commitment to following this up by re-arranging when possible.

Annual appraisal had been 90% compliant in the last financial year. From April 2016 to July 2016, whilst some managers had been away, this had decreased to 83%. The registered manager was aware there was additional work to do to rectify this.

The hospital manager or deputy manager chaired meetings for the staff team, these included: staff and night staff meetings for all grades, qualified nurse meetings and support worker meetings. Staff told us they would attend if possible however, leaving the wards could be difficult and travelling in specifically for a staff meeting was something staff did not wish to do on days off. Minutes of meetings were circulated to all staff. In addition, regular psychology meetings, attended by the service director and psychologists and companywide managers meetings, attended by the executive team, all hospital managers and senior clinicians took place.

In addition to mandatory training, staff training adapted to meet the needs of patients in the service had been available in the last year:

- Physical healthcare needs including epilepsy, diabetes and dysphagia (swallowing difficulties).
- Specific training to increase staff understanding of autism, self-harm, child protection and adult abuse.
- Collaborative risk assessments, working with patients to understand, assess and reduce their risk of violence.
- Restrictive practice, encouraging staff always to consider the least restrictive intervention possible.
- Life Star training, working with adults with learning disabilities using an outcome tool to support and measure change.
- See Think Act training, the knowledge and understanding the staff have of a patient and the environment, so staff can give appropriate responses and provide effective care.

Staff told us training, supervision and appraisal made a positive difference to practice. Poor staff performance was addressed using the provider's human resource performance management processes. These included supervision, appraisal, investigation meetings, managers role modelling and giving feedback, file notes, training, a variety of warnings as per disciplinary policy and dismissal. We reviewed three staff files during the inspection, and found the processes followed matched with policy.

Multi-disciplinary and inter-agency team work

Monday to Friday a daily morning meeting, attended by members of the multidisciplinary team, managers and the nurse in charge of the day shift was held to aid communication across the whole team. On a Monday, this meeting was longer so a handover of the weekend was possible. We attended a morning meeting which had a focussed agenda and saw clear decisions made, when needed about who would complete specific tasks, for example a safeguarding referral.

Handovers between shifts took place morning and evening with all nurses and support workers coming on duty in attendance. This meant all staff had an awareness of all patients. Staff allocation was agreed at the handover, this included any planned leave, appointments or meetings during the shift for individual patients.

The multidisciplinary team meeting took place weekly. Ahead of a patients' meeting team members completed summaries of their involvement in the form of a brief report. This was given to patients ahead of the meeting, when they too were encouraged to comment on how they were.

We saw an agenda containing graphics and adapted language that explained what would happen during the multidisciplinary team meeting. This covered

introductions; notes and actions from the previous meeting; progress; medicines; obstacles; outcomes; capacity; risk; patient requests; plans for discharge and actions from this meeting.

We observed a multidisciplinary team meeting where patients were encouraged to chair their own meeting using prompt cards to follow the agenda. The patient was asked if they knew and were comfortable with everyone in the room remaining, the patient was happy with the attendees. Previous minutes circulated showed the attendance list at this patient's multidisciplinary team meeting had been consistent with the one we observed.

The patient was empowered to speak about their concerns, with time given so they could say what they wanted to. At one point when explaining an incident the patient became upset, members of the multidisciplinary team were compassionate and reassuring. Conversation was easy and informal. The consultant guided and supported the patient to keep to the agenda. The patient asked each team member about the progress they had made. The patient knew what medication they were on and knew roughly, why. They were also aware of the decisions the second opinion appointed doctor had made. The meeting focussed on the patient, their views and needs with agreed actions clearly re-iterated with the patient.

We saw a chair's checklist for multidisciplinary team meetings completed and signed, its contents mirrored the accessible agenda used by patients. The final minutes recording the meeting included the notes made ahead of the meeting and an action plan agreed at the meeting, creating a comprehensive recording of what had taken place.

No family had been present at the meeting. When asked why not, staff told us they probably could not make it, but would have been asked. We saw neither a check that relatives had been asked, nor apologies from them within the documentation or the meeting.

Members of the multidisciplinary team spoke of working together with the patient at the centre of their care. Although practitioners did not always agree, they were able to discuss differences and work collaboratively to meet the needs patients. Practitioners who had been part of the hospital team for some time told us they welcomed the breadth of expertise the wider team offered. Those newer to the service were working to ensure each patient had the assessments they required as a baseline for specific care. For example, the occupational therapist was completing sensory assessments to find out how individuals processed everyday sensory information. For many people sensory differences can affect behaviour and have a profound effect on a person's life.

Staff planned care programme approach meetings in advance and encouraged patients, relatives and external agencies to attend. We observed a care programme approach meeting where the patient refused to attend. The social worker, nurse, assistant psychologist, mental health administrator and the independent advocate were part of a full discussion. An outcome was agreed in the absence of the patient and external agencies that included arranging a further care programme approach meeting. The advocate and social worker were to discuss this and the other proposals with the patient concerned.

There was a contract for the practice nurse to visit weekly and the general practitioner monthly to meet physical health needs of patients. The general practitioner was also available at the practice if an urgent health need arose however; it was not always practical to take a patient to the surgery to access the doctor there. Nurses had been concerned that access for some patients, if they had an urgent medical need was not timely. Prescriptions were posted from the surgery to the pharmacy, on one occasion it had taken 10 days for the patient to receive medication prescribed by the general practitioner. They had also been concerned they were not receiving feedback, including test and blood results. We saw a communication book designed to capture this information for the hospital staff, however although specific questions had been asked by hospital staff, there was no response recorded in the book by the visiting practitioners and they could not access this information electronically. One relative had raised some specific concerns about the physical health of a patient and remained unsure if the general practitioner was treating these properly.

The hospital manager had arranged a meeting with the general practitioner practice; this had been cancelled on two previous occasions. During the inspection period, this meeting took place. From meeting minutes, we saw agreements that in future prescriptions would be emailed or faxed minimising delay. The hospital would be able to access electronic health information including the annual health check and specific test results. Any additional

communication regarding patient's treatment would be retrieved from the general practice electronic system so copies can be forwarded to the hospital for their records. We had assurances from the hospital manager that what had been agreed at this meeting would be monitored closely.

There was a positive relationship with North Lincolnshire safeguarding team who took referrals and supported investigations. Staff reporting safeguarding felt supported by this team and able to call them for advice.

Management told us the local police would attend an incident and respond sensitively if called in an emergency. At the time of the inspection, following an allegation made by a patient mid-May the police had cancelled two appointments to interview the patient with the support of the advocate. Although the hospital had acted immediately to keep the patient safe, the appropriate body had still not heard the patient's allegation.

Adherence to the Mental Health Act 1983 and the Mental Health Act Code of Practice

Staff received training in the Mental Health Act 1983 as part of their induction programme. Clinical staff had received annual updates in the Mental Health Act and were 91% compliant. We reviewed the content of this training, which included amendments to the Code of Practice and the guiding principles. An easy read guide and update was available on the provider's intranet.

Completed consent to treatment forms were attached to medicine charts where applicable. We saw examples of capacity reviews to accompany consent to treatment documentation. The responsible clinician told us that they reviewed all certificates of consent to treatment a minimum of every two years, completing a capacity assessment at the same time.

Staff informed patients of their rights verbally and through written and pictorial formats. Patients described having their rights explained to them regularly. We saw evidence on the database that recorded the reading of rights in relation to sections of the Mental Health Act, this included documentation of the frequency of conversations along with the person completing the review and the outcome or level of understanding of material.

The use of the Mental Health Act was appropriate, with detention documentation complying with the Mental Health Act Code of Practice. The provider had a Mental Health Act administrator who completed audits and scrutinised documentation. For individual patients the system in place flagged important dates, for example: tribunals, renewals of detention and deadlines for reports. The administrator then ensured patients and staff were aware of these timescales. Original copies of documentation were stored securely in the Mental Health Act administrator's office, with copies available on the ward.

In addition to training, the staff we spoke to felt supported by the Mental Health Act administrator who was available to answer specific queries they might have. If the administrator had any concerns or queries, they had access to a solicitor with expertise in relation to the Mental Health Act. We saw quarterly audits completed of Mental Health Act documentation and Section 17 leave.

Patients would request section 17 leave as part of their multidisciplinary team meeting. At other times, an individual patient request could be made with the support of their named nurse and/or an advocate. Staff completed risk assessments prior to patients taking section 17 leave. The multidisciplinary team then reviewed the planned leave at the morning meeting. We saw leave forms that were clear and struck out or ended after review. The original forms were kept in the patients' legal file, with two copies made, one for the patient and one for their file in the ward office. Every three months a copy of section 17 renewal was sent to the patient's family with their consent.

All section 17 leave due was discussed each day in the morning meeting. A risk assessment prior to leave was carried out for each patient and the hospital. If any planned leave needed to be rearranged due to risks identified within the hospital, for example, its effect on staffing levels, the process was that a new date would be set when a patient's leave would happen. We were also told that to manage risk within the hospital planned leave might be brought forward to ensure it could happen.

The provider had a contract with an independent mental health advocacy service that provided three days cover at the hospital each week. All patients were able to access this service. Four patients told us they could go to the advocate if they had a problem. Patients who were unable to ask for

an advocate were on what was described as a watching brief, where an advocate made sure each patient was seen at regular intervals. We saw attendance by the advocacy service at relevant meetings.

Good practice in applying the Mental Capacity Act 2005

All staff received training in the Mental Capacity Act 2005 as part of their induction programme. Following induction, specific update training included a test for attendees to check staff understanding of their learning. We reviewed the content of the training, which focussed on the practical application of the law in relation to the patient group. Staff mandatory training, which had been updated in November 2015, showed 91% compliance.

In addition to this training, staff understanding of the Act was measured through discussion within supervision, during safeguarding and incident reviews. We were also told the service director and compliance lead had spent face-to-face time discussing Mental Capacity Act with staff in the service, which was followed up during daily management walk-rounds where discussions with staff kept the issue live in practice.

The staff we spoke to had good knowledge of the assessment process and the basic statutory principles of the Mental Capacity Act 2005. Staff were aware of and could refer to the provider's policy on the Mental Capacity Act.

Capacity was part of the set agenda at care programme approach meetings and care and treatment reviews, which involved relatives, and for each patient at their multi-disciplinary team meetings. Deprivation of liberty safeguards were not required because all the patients at Bradley Woodlands were detained, staff understood this and staff told us they followed the principles least restrictive practice when delivering care.

Staff described specific decisions made in a patient's best interests as considering what needed to happen from the perspective of what a patient would want based on the knowledge and understanding they had of this.

Formal Mental Capacity Act documentation was available and appropriate. In the records, we saw examples of capacity assessments and paperwork relating to best interest decisions. There was evidence of the questions asked and patient's responses to questions from Mental Capacity Act assessments. The language used reflected the patient group. Questions asked were revisited to assess the patients' understanding and retention. We saw an example of a finance assessment completed by the social worker using graphics and adapted material.

Whilst there was no specific audit to monitor adherence to the Mental Capacity Act, staff awareness of the importance seemed high, the documentation was checked in the quarterly records and documents audit.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

During inspection we spoke with six patients, spent time in the ward environment, observed an activity group and a multidisciplinary team meeting.

The patients we spoke with told us staff were polite; most spoke nicely, though others did not because they shout. We also heard that some staff really care. Most patients said they could talk to staff if they became upset. Two patients told us staff had explained the medicines they were taking to them. One patient described restraint as being calm when it happened.

Patients knew their named nurse, key worker, the names of care staff and the hospital managers.

Patients liked having their own en suite room with their own belongings in their apartment. Most patients seemed happy to share their apartment with others.

The activity group was responsive to the needs of the patients attending. Two staff members gathered patients together away from an incident and re-organised what had been planned until other staff became available. We observed a caring attitude throughout. The staff involved remained calm, managing a difficult situation positively.

We observed staff encouraging patients, offering appropriate support that was practical and emotional. The staff and patient interaction seemed both familiar and comfortable. Support staff caring for patients understood the individual needs of the patients in their apartment.

Relatives described staff as respectful and polite. They found staff to be caring and supportive of patients. They also commented positively about the importance of patients having personal belongings with them.

The involvement of people in the care they receive

The orientation of new patients to the ward was supported by care staff and established patients who knew the hospital. Named nurses spent time with their patients involving them in care planning, goal setting within a recovery pathway. Person centred approaches increased involvement with aids, examples were pictorial; easy read; story boards or Makaton used depending on the patient's needs. One patient spoke of being really involved in their care planning and really supported by staff to do this. Support workers had access to individual care plans in the apartments.

We saw individual examples of activity timetables that drew from a breadth of choice patients had. Patients told us they had a choice of activities, though there were fewer provided at the weekend. Patients particularly enjoyed going out of hospital into the community, however those near discharge would like to do so more often. There was some frustration expressed by patients when changes and cancellations were made to planned activities. Some relatives expressed concerns about cancelled activities; others believed there were always things for patients to do within the hospital. In the three months May to July 2016, 496 activity sessions had taken place within the hospital; some were one to one, others within a group.

Patients were encouraged to chair their own multidisciplinary team meeting where meeting using prompt cards to follow the agenda. In the meeting we attended, the patient was empowered to speak about their concerns, with time given so they could say what they wanted to. The meeting focussed on the patient, their views and needs. Any concerns about risk were openly discussed and all agreed actions clearly re-iterated with the patient.

From file reviews, we saw evidence that patients had engaged in care and treatment reviews. Care and treatment reviews have been developed as part of NHS England's commitment to improving the care of people with learning disabilities with the aim of reducing admissions and unnecessarily lengthy stays in hospitals and reducing health inequalities. We also saw evidence that patients and their families had been actively involved in care programme approach meetings. These are meetings used to plan, co-ordinate and review the care for someone with mental health problems or a range of related complex needs.

Patients and relatives described being a long way, geographically, from each other as difficult. Arrangements to speak on the telephone were individually care planned and appeared to work well. In addition to direct telephone contact with patients, relatives could call the hospital for updates from staff. Two relatives described limited information given to them by nurses on the telephone, with patient confidentiality quoted when asked what could be perceived as a difficult question about why something had or had not happened.

Patients nearing discharge felt home leave once a week was not often enough. Relatives with a patient working towards discharge felt that planned visits home were not regular enough. Relatives of three patients spoke positively about staff facilitating patient visits home. However, we heard of two recent examples of home visits cancelled at the last minute. Both were re-arranged, but this was described as be very hard for both patients and their relatives at the time.

Relatives were invited to care programme approach meetings, received information ahead of these meetings and minutes afterwards. They felt listened to by staff within these meetings and had their questions answered. Relatives described good clear communication with doctors and nurses in this forum. Communication from the hospital to relatives included regular written reports. However, relatives did not always feel well informed outside of meetings. They had concerns that some care workers seemed to know little about specific decisions or agreements previously made. This led to times when what was or was not allowed was not always consistent or linked to care planning. Relatives described variations, depending on who was on duty, as making a difference to the mood of patients.

Relatives with patients who had been within the service for some time described the care and treatment delivered as becoming clearer to them. They believed a lot went into ensuring patients at Bradley Woodlands remained safe. Relatives had recently been invited to join patients at a 'Wellbeing Day' at the hospital.

Good

Forensic inpatient/secure wards

All patients had access to an independent mental health advocate within the hospital three times a week. This could be face-to-face or using a dedicated advocacy telephone. There was an open referral system for any staff or patients to ask for support. The patients we spoke to all knew the advocate was available and that they could see them if they wished to. The advocate we spoke with knew the patients within the hospital and held a clear separation between their role as independent from the hospital team.

In addition to a daily walk around by managers, monthly community meetings with the hospital manager and an advocate attending gave the patients direct access to management to formally discuss any issues and make suggestions. Two patients were concerned that community meetings in the hospital had not been held as regularly in recent months whilst managers had been off. To encourage feedback and discussion about changes within the service, patients and staff could attend an involvement forum held weekly.

We reviewed the quality network for forensic mental health services survey 2015/16. This had been completed by 14 patients with the support of the independent advocate. Overall, patients who responded to the survey answered 28 of the 30 questions asked about the service positively. For the other two questions, half said they had been offered the chance to learn job skills, the other half had not and two thirds of patients had been asked for feedback about the service, one third had not.

The family and friends survey asked 15 questions and had been completed by four people. This identified there had been consultation and involvement of carers about the care being provided to patients, Most carers felt the staff were respectful to their relative, all found the staff respectful to themselves. Two carers felt visiting their relatives had been facilitated by the hospital two did not. Carers were asked for feedback about the service however, were not aware of any changes as a result of this.

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

Good

Access and discharge

Average bed occupancy over the six months February to July 2016 for the hospital was 86%.

NHS England commissioned all patients after an access assessment and care and treatment review. In the last six months, eight patients (44.5%) were from the Yorkshire and Humber area, eleven (55.5%) were not.

Beds were available when needed to people living in the catchment area. As this service meets specialists commissioning requirements all referrals and consequent admissions were arranged by NHS England via access assessments.

Following a referral and a review of paper information, arrangements were made to go to meet the patient, the referring team and if possible the patients' relatives. A pre-assessment meeting involving qualified nurses, the multidisciplinary team and managers then took place to agree the admission or not. If a patient's needs could be met by the hospital, their admission was planned. If following pre-assessment an individual could not have their needs met by the service there was a right to refuse admission. Once a referral was accepted, admission to the hospital could happen within a day.

Staff told us that before a new patient arrived, the named nurse communicated an admission plan to the staff team. Managers increased staffing to facilitate a successful admission and support changes in the wards. New patients received a welcome pack to the hospital. Staff supported patients to understand the contents of this easy read document if needed.

Patients were not moved between wards during an admission. If patients went on leave there was access to a bed on return. If a person required more intensive care this would be discussed within the multidisciplinary team and the commissioners approached to review the placement. The movement or discharge of any patient would be planned to happen at an appropriate time of day.

Patients at Bradley Woodlands had their progression and discharge considered from the point of admission. We saw a referral, admission and discharge progression pathway document in use that considered the future needs of each patient on discharge from hospital.

Most patients became actively involved in their multidisciplinary team meetings and care programme approach reviews. At both, discharge was part of the

agenda. There were good examples of discharge pathway documentation with future placement options related to an individual patients need. Staff informed us that some patients had visual discharge pathways, it was the plan that all patients to had this by the end of the year.

We heard about an open dialogue with relatives, the patient's care co-ordinator and any future care provider. Two families described the hospital as the best service their relative had received. This has led to heightened concern when there is talk at meetings of discharge. Most relatives were concerned that alternative suitable placements for patients with complex needs seemed very limited.

In the last six months, there have been two delayed discharges from the hospital. For both patients this was due to clinical commissioning groups delay in providing appropriate move-on services.

The facilities promote recovery, comfort, dignity and confidentiality

The reception area at Bradley Woodlands was welcoming, with names of hospital managers and first aiders clearly displayed. There was a maintenance team, gardener and a housekeeping service to up keep the facilities.

The environment was clean however, some of the furnishings looked in need of replacement and décor was tired. New bedroom furniture was on order with a schedule for redecoration within the apartments to coincide with its delivery. Improving the ward environment raised specific challenges because of the disruption it could cause however; there was an on going schedule for this work throughout the hospital, with a completion date of March 2017.

Bedrooms remained unlocked and were accessible to patients during the day. Patients' rooms were personalised and patients had chosen colours for the redecoration of their room. It was rare that patients moved from their room unless the dynamic in an apartment was detrimental to patient's recovery. If a risk assessment highlighted specific concerns, staff removed items from bedrooms, these would be returned as risks lessened.

Each apartment had drinks and snacks available 24 hours a day. Weekly menu planning took place in apartments. Staff and patients shopped for their food, or completed an apartment shop online. Food preparation took place in apartment kitchens. This was supported by activities including food safety, baking and meal preparation with individuals and in small groups.

A large activity room could be divided into two rooms for different therapies or activities. This included cooking facilities for patient use. We saw artwork created by patients on the walls. Patients had access to a large gym with a range of equipment and a pool table. An interactive sensory room with fibre optics, projected lights and a bubble tube was used for relaxation and sensory stimulation. This required patients to undergo individual risk assessments prior to use. A laundry was available for patients to use as part of their rehabilitation.

Doors on self-closing hinges banged shut in the ward environment. During inspection, one alarm raised sounded for over five minutes. One patient became upset when the alarm sounded, saying they hated all the noise in the hospital.

The visitor rooms and the advocacy office were private and available for use away from the ward area. Relatives described staff as being supportive and accommodating when arranging for them to visit. However, it had been difficult over the Christmas period 2015 when there was limited use of the visitors' rooms due to a review of some kind. Two relatives saw this as an inappropriate priority for these rooms given the time of year. For some patients staff had facilitated visiting within the grounds or outside of the hospital.

Patients could make telephone calls using their mobiles, or an internal phone in the visitor's room. At the time of our inspection, mobile phones were kept for individuals at reception. However, a decision had been made that from the end of August 2016, personal mobile phones would be kept in the patients' apartment so access would be quicker, and subject to a risk assessment, patients would be able to make calls from their bedrooms.

The central courtyard offered patients a secure outside space where they could walk or socialise. Unescorted access to a secure garden was possible for some patients following a risk assessment. Outside the hospital, the grounds were extensive, quiet and well maintained. The allotment area allowed patients to grow produce for meals.

We saw a list of 36 activities available to patients. Staff supported patients to plan activities each week. Copies of

individual plans were kept by the patient and in their individual file where it would inform support staff each day. Patients told us they had a choice of activities and individual activity timetables showed this, however they also expressed frustration when changes were made to planned activities at the last minute. Some patients complained there was less to do at the weekend others did not. Activities staff did work some Saturdays, however they told us patients were less interested in attending structured activities, preferring to relax more at weekends.

One of the aims of the individual activity plans was to reflect patients own choices. Over the summer, all patients had been given an interest checklist to complete. These informed staff in more detail about likes, dislikes and aspirations. The completed documents would form the basis of a further needs assessment by the occupational therapist.

For most patients an offsite activity was planned a minimum of weekly. There was some frustration expressed by patients about the cancellation of external visits for example, into the community to shop. Some relatives expressed concerns about cancelled activities; others believed there were always things for patients to do within the hospital.

Meeting the needs of all people who use the service

The hospital was on one floor with disabled access throughout. We saw adjustments made to accommodate specific physical care needs of individual patients.

Easy read text and pictorial leaflets about aspects of care, for example: patient information about occupational therapy and the rights of detained patients were available.

Person centred plans containing signs and graphics chosen by individual patients, assisted understanding and supported the written information within the plan.

We saw examples of communication passports; capacity assessments; interest checklists; activities of daily living assessments and visual discharge pathways, containing graphics and adapted language.

An accessible agenda and prompt cards in multidisciplinary team meetings supported patients to chair their own meeting. Notice boards displayed accessible information about detention in hospital and advocacy.

At the time of our inspection, English was the first language for all patients. We were assured that if there was a need to translate information into different languages, this could be done by the provider.

During meal planning the staff worked with patients to ensure that specific dietary needs were met, this included patients in the hospital requiring coeliac and diabetic diets. In addition, the hospital could accommodate any specific dietary requirements of patients for religious reasons. Patients' birthdays were celebrated with a party and buffet of their choice.

Support of individuals to meet their spiritual needs included celebrations of the Christian festival of Easter and the Islamic festival of Eid.

Listening to and learning from concerns and complaints

The hospital managers told us they support the patients to use the complaints procedure and to highlight any suggestions or concerns either formally or informally.

Patients told us they would complain to the manager, the advocate or their relative. Relatives said they would complain, if needed, to management or the doctor in charge. Staff told us they would pass complaints to a manager on site or in their absence the senior nurse on the shift.

In the twelve months prior to July 2016, 57 complaints were received at Bradley Woodlands.

Of these, ten were upheld and no complaints had been referred to the ombudsman.

The 47 complaints not upheld, usually related to the patients mental state at the time of the complaint and something distressing them. We were told that in order to ensure the management were responsive; they actively listened to concerns raised and acted accordingly.

Complaints were discussed at the multidisciplinary morning meeting where any follow-up actions were identified. The hospital manager spoke with patients informally following a verbal complaint, giving feedback to the individual concerned.

Following a more formal complaint, we were told staff and/or patients received feedback on the outcome of investigation of complaints by both face-to-face meetings and letter.

Good

Forensic inpatient/secure wards

We reviewed seven written complaints, six internal from patients, and one external. We saw that these complaints had been recorded and reviewed according to the providers' process. However, we saw no detail of any investigation having taken place. Copies of letters written in response to each complaint were formal in nature and it was unclear how accessible this format would be to the patients in receipt.

In addition to complaints, the hospital told us they had received several compliments, both formal and informal in the last twelve months. These included positive feedback about: the core team training delivered by the hospital to the care and treatment review panel; and the care, treatment and safety a relative experienced whilst on the hospital site.

Are forensic inpatient/secure wards well-led?

Good

Vision and values

The philosophy of the provider is of empowerment and inclusion, with a focus on rehabilitation that encourages patients to make choices in the decisions affecting their lives.

At Bradley Woodlands, the management team expressed an aspiration to put patients at the heart of the service. We heard key messages to staff about patient centred care and positive behaviour support, with the least restrictive option observed at all times. The staff we spoke to were aware of these messages and had a commitment to work towards their achievement.

Staff knew who their local and senior managers were. A daily walk round by the deputy manager or lead nurse fed information from patients and staff into the morning meeting. Senior managers from the organisation visited the hospital regularly. They had assisted in providing on site management cover early in the summer.

Good governance

Staff compliance with annual appraisal was 90% in the last financial year; from April 2016 to July 2016 this had dropped to 83%. The registrations of all clinical staff were in date.

The provider's policy had a minimum standard that all staff received supervision that included both management and clinical aspects no less than quarterly; this standard showed a compliance of 100%. However, in line with low secure standards the service continued to work towards increasing supervision for all clinical staff to monthly supervision. We received no figures in relation to this target.

The hospital target for mandatory training was 80% in 2015 this target had been 90%. The administrator who monitored training was not aware of this change. The database used to record and monitor staff training highlighted training due, completed and overdue. This showed compliance with staff induction of 73%. We were told all staff had received an induction to the hospital but the dates were not recorded for staff that did so before 2007. Of the 27% of staff not recorded as attending induction, none had completed the hospital's induction refresher.

Staff compliance with the nine core elements of mandatory training including updates was 90%. However, for nurses and support workers required to complete food hygiene every three years, compliance was 75% and for registered nurses only, medication management showed a compliance of 50%.

The hospital had a system in place to determine the staffing levels. This linked to the individual needs presented by each patient. The staffing levels were checked and reviewed by the management team, and could be adjusted according to need. There was a mismatch on a day shift between the stated establishment of qualified nurses and the number determined by the providers staffing ladder. At times, nursing staff felt under too much pressure to complete their workload.

Whilst the deputy manager took the lead to ensure that regular clinical audits took place, staff contributed to their completion. Learning from quarterly clinical audits had included an improvement of documentation for security checks; hand-washing posters put up across the hospital; improved recording of one to one sessions with staff; greater consistency and compliance in the application of the Mental Capacity Act and improved practices in infection control. More specialised training for staff had been set up and attended, this included the introduction of 'See Think Act' training designed for staff working in secure settings

that focussed on appropriate responses and care. Although medicines audits had been completed neither the internal, nor the external audits had identified the issues found on the first day of inspection.

The hospital followed procedures in recording and reporting safeguarding concerns. Staff clearly understood the processes to report safeguarding. Lighthouse healthcare had developed its own safeguarding spread sheet that ensured the management team had a consistent and easy over view of trends. We saw processes in place that monitored adherence to the Mental Health Act and the Mental Capacity Act.

Staff knew how to report incidents. Reviews of incidents relating to patients took place in the morning meeting by the multidisciplinary team, and as part of meetings related to patient care. Other reviewing processes included incident analysis meetings; serious incident reviews; clinical governance; health and safety meetings; hospital planning meetings and executive team meetings. The minutes from these meetings were available to staff.

The registered manager had sufficient authority to manage the hospital and had the authority and processes in place to raise issues at provider level. The service was required to report on key performance indicators. The manager submitted a monthly report to the executive team, and was sent from headquarters on a monthly basis budget and occupancy reports. Commissioning for quality and innovation and quality dashboard returns were made quarterly to NHS England. These tools monitored the quality of the service provided. The registered manager was also the hospitals controlled drugs accountable officer and produced quarterly reports to the local intelligence network.

Annually the quality network for forensic mental health peer reviewed the hospital. The last review had been in January 2016 where the hospital achieved a score of 88% against a benchmark of 90%. This showed a significant improvement, the review in 2015 had scored 69% with a benchmark of 81%.

Guidance from National Institute for Health and Care Excellence, the Department of Health guidance alongside specific guidelines form other professional bodies, for example, the British Institute of Learning Disabilities informed the provider's policy reviews and updates.

Leadership, morale and staff engagement

The hospital managers told us they support our patients to use the complaints procedure and to highlight any suggestions or concerns either formally or informally.

Patients told us they would complain to the manager, the advocate or their relative. Relatives said they would complain, if needed, to management or the doctor in charge. Staff told us they would pass complaints to a manager on site or in their absence the senior nurse on the shift.

In the twelve months prior to July 2016, 57 complaints were received at Bradley Woodlands.

Of these, ten were upheld and no complaints had been referred to the ombudsman.

The 47 complaints not upheld, usually related to the patients mental state at the time of the complaint and something distressing them. We were told that in order to ensure the management were responsive; they actively listened to concerns raised and acted accordingly.

Complaints were discussed at the multidisciplinary morning meeting where any follow-up actions were identified. The hospital manager spoke with patients informally following a verbal complaint, giving feedback to the individual concerned.

Following a more formal complaint, we were told staff and/or patients received feedback on the outcome of investigation of complaints by both face-to-face meetings and letter.

We reviewed seven written complaints, six internal from patients, and one external. We saw that these complaints had been recorded and reviewed according to the providers' process. However, we saw no detail of any investigation having taken place. Copies of letters written in response to each complaint were formal in nature and it was unclear how accessible this format would be to the patients in receipt.

In addition to complaints, the hospital told us they had received several compliments, both formal and informal in the last twelve months. These included positive feedback about: the core team training delivered by the hospital to the care and treatment review panel; and the care, treatment and safety a relative experienced whilst on the hospital site.

Commitment to quality improvement and innovation

Good

Forensic inpatient/secure wards

New electronic recording systems have enabled improved methods to review incidents and triangulate data more easily to help define causes and act more promptly to prevent recurrence. Alerts from these systems went directly to the executive team and on call managers keeping them informed.

The organisation had developed a staff member to deliver in-house conflict management training. This had meant staff received bespoke training that allowed a quick response to changes in patient behaviours and management plans. This person centred approach included individual risk assessments and de-escalation strategies.

Bradley Woodlands participated annually in peer reviews as part of the quality network for forensic mental health services accreditation scheme for medium and low secure hospitals. The hospital was also part of NHS England's commissioning for quality and innovation. A scheme intended to deliver clinical quality improvements and drive transformational change, reducing inequalities in access to services.

The hospital was also involved in the national recovery and outcomes group; Yorkshire and Humber involvement forums; the patient and carer involvement initiative with NHS England; as Yorkshire and Humber care and treatment reviewers and as part of the national learning disability census.

Outstanding practice and areas for improvement

Outstanding practice

Patients from the hospital take part in the Yorkshire and Humber involvement forum each quarter.

The hospital completed a scoping exercise to understand how the independent mental health hospitals in Yorkshire and Humber engage with patients and carers for NHS England in July 2016.

The Royal College of Psychiatry quality network for forensic mental health services peer review in January 2016 achieved 88%, a significant improvement on the previous review for Bradley Woodlands in 2015 that achieved 69%. The benchmark is 90%.

Staff had participated in the national recovery outcomes group and worked as care and treatment reviewers within the Yorkshire and Humber region.

Areas for improvement

Action the provider MUST take to improve

- The provider must regularly check the emergency equipment so it remains suitable for use.
- The provider must ensure storage of drugs are at the correct temperature to keep medicines safe.

Action the provider SHOULD take to improve

- The provider should ensure enough qualified nurses on shift to complete the duties required.
- The provider should ensure the contracted primary care provider meets the needs of the service users in relation to the management of their physical health needs.
- The provider should ensure all staff treat patients with respect. For example, the use respectful communication when interacting with patients.
- The provider should undertake an impact assessment prior to completing maintenance work, which may affect the patients in the hospital.
- The provider should ensure that clinical audits to monitor practice are comprehensive.
- The provider should ensure that all aspects of the patient complaints procedure is accessible to all.
- The provider should strive for section 17 leave to take place as originally planned with patients and relatives.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met Oxygen kept in ward office contrary to the notice in the ward clinic. Oxygen checklist last completed 26 March 16. Emergency equipment box and defibrillator kept in ward office with no external notice to indicate this. A number of items in the box had expired. Other items including the two manual suction pumps and facemasks appeared used and not sterile. The defibrillator last checked 4 January 16. The suction catheter went out of date June 2016, sterile gloves went out of date December 2015. There was no content list within the emergency box. Fridge temperatures in the clinic room were last checked on 24 March 16. The last entry noted two thermometers were not working, these were not working on inspection day one 9 August 16. This was a breach of Regulation 12 (2)(e)(g)