Arbury Court

Quality Report

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

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.

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

Summary of findings

Overall summary

We rated Arbury Court as **outstanding** because:

- Patients were actively involved in their risk assessments and care planning. This included training patients to complete their own risk assessment with staff.
- Care plans were patient centred and recovery focused. Patients had an assessment of their needs which included their mental and physical health and level of risk.
- The service had implemented a positive behavioural support programme called RAID (reinforce appropriate implode disruptive). This was a philosophy of care that focused on patients' positive behaviours, strengths and recovery.
- Patients were actively involved in making decisions about the service. This included through the patients' council and community meetings.
- The majority of patients and carers we spoke with were positive about staff and felt they treated them with respect and kindness. Interactions between staff and patients were friendly and respectful.
- The service used a 'dashboard' to oversee key information about patients. This improved patient care because staff routinely reviewed this and acted when they saw gaps.
- The service used information from the dashboard to monitor and improve the quality of care. This was monitored locally, corporately through Partnerships in Care, and by the service's commissioners.
- The provider used a staff satisfaction tool that showed staff at Arbury Court were generally positive about the service. This was reflected in our conversations with staff.
- There were adequate facilities for patients within the hospital which include activity and therapy rooms, and secure storage for patients' possessions including valuables and restricted items.
- Patients received care from a multidisciplinary team that included doctors, nurses, occupational therapists, psychologists, social workers and healthcare support workers and activity workers. The service employed a registered general nurse and healthcare assistant who led on patients' physical healthcare needs. All patients were registered with a local GP.
- Patients had access to occupational therapy and had at least 25 hours of planned activity per week. There was a programme of 'real work' opportunities where patients were interviewed, selected, trained and paid to do jobs in the hospital.
- The use of seclusion was in accordance with the Mental Health Act code of practice.
- There were security procedures for the safety of patients, staff and visitors.
- Restraint, enhanced observation, seclusion and long-term segregation were used with patients. This was routinely reviewed, and changed to least restriction when possible.
- The service had high levels of incidents. However, it reviewed and acted upon these at a local and corporate level.
- Staff received regular supervision and appraisal.
- Permanent, bank and agency staff covered nursing and healthcare worker vacancies. The service had a recruitment strategy and an employment engagement lead to increase recruitment and retention in the service. Staffing allocations were reviewed daily and weekly to ensure that safe staffing levels were maintained, and that patient care was provided including therapy, leave and activities.
- Staff implemented safeguarding policies to identify and report potential abuse.
- The nature of service meant that there were necessary restrictions imposed, particularly with regards to safety and security. Staff were mindful of this and the use of blanket restrictions, when applied, was with consideration.
- The service had implemented a healthy eating and fitness programme. The service was balancing its duty of care to patients who were overweight or clinically obese, with patient choice and least restrictive practice.
- Overall, staff managed and administered medication appropriately.
- Overall, the Mental Health Act was implemented in accordance with the code of practice.

Summary of findings

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Outstanding ☆

Arbury Court

Services we looked at
Forensic inpatient/secure wards

Summary of this inspection

Background to Arbury Court

Arbury Court is registered to provide the regulated activities: treatment of disease disorder or injury; assessment or medical treatment for persons detained under the Mental Health Act 1983; and diagnostic and screening procedures. The service has a registered manager and an accountable officer.

Arbury Court provides one core service: forensic inpatient and secure wards.

Arbury Court provides secure inpatient services for up to 74 women with a mental illness or personality disorder.

Arbury Court has two medium secure wards and four low secure wards. Delamere and Oakmere wards are medium secure and both have 11 beds. Low secure services are provided on Cinnamon and Rosewood wards, which have 11 beds each, and Appleton and Heathfield wards, which have 15 beds each.

We have inspected Arbury Court four times since registration with the Care Quality Commission (CQC) in 2010. The last inspection took place on the 23 September 2013, and the service was found to be compliant with the regulations.

Our inspection team

Lead Inspector: Rachael Davies

The team comprised four CQC inspectors, a CQC Mental Health Act Reviewer, an expert by experience, a nurse, a pharmacist and a psychologist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit we reviewed information that we held about the location, and asked a range of other organisations for information about the service. We sought feedback from patients at two focus groups and staff at three focus groups.

During the inspection visit, the inspection team:

- visited all six wards and other facilities at the hospital, looked at the quality of the environment and observed how staff were caring for patients;
- spoke with 26 patients and the relatives of four patients;
- spoke with the hospital manager;
- spoke with 36 other staff members; including doctors, nurses, healthcare support workers, allied healthcare professionals such as occupational therapists and psychologists, a social worker and support staff;
- spoke with an independent advocate;
- attended and observed five multidisciplinary meetings, three community meetings, two daily management meetings and one hand-over meeting;
- collected feedback from 18 patients using comment cards;

Summary of this inspection

- looked at 14 care and treatment records of patients, and other patient care records in multidisciplinary team meetings;
- carried out a check of the medication management on five wards which included reviewing the prescription charts;
- reviewed how the Mental Health Act was implemented which included a specific visit of Rosewood ward; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We observed interactions between staff and patients that were friendly and respectful. The majority of patients we spoke with were positive about staff and felt they treated them with respect and kindness.

The hospital carried out an annual patient satisfaction survey in January and February 2015. Of the 51% of patients who responded, 89% rated their overall care as good, very good or excellent, and 11% thought it was fair or poor. The service used the 'friends and family test', which was at 100%. This meant that all patients who responded would recommend the service to friends and family.

There were weekly community meetings on all of the wards. Patients raised concerns and made decisions about issues on the ward. These included changes to the ward timetable and decisions about activities. For example, after patients on Appleton ward requested a visit to a large shopping centre and to a garden centre, staff supported patients to do this. Patients had also requested an exercise bike, which they now had. In the approach to Christmas, staff discussed and agreed the timing and menu for Christmas meals with patients.

The service encouraged patients to share their views and opinions, and contributed towards improving the service. Each ward had a patient representative who attended a regular patients' council. The council was involved in decision making about the service. Patient representatives also participated in the ward planning and developmental team meetings, redevelopment meetings, and clinical governance meetings.

Patients were very positive about the "Pets as Therapy" initiative, which included a hospital dog, guinea pigs and rabbits.

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?

Good

We rated safe as **good** because:

- Environmental risk assessments and ligature audits had been carried out and were reviewed regularly.
- There were effective security procedures to ensure the safety of patients, staff and visitors.
- The required emergency equipment was available, regularly checked and all staff knew where it was located.
- Seclusion rooms were in keeping with the Mental Health Act code of practice.
- Staffing allocations were reviewed daily and weekly to ensure that safe staffing levels were maintained, and that patient care was prioritised including therapy, leave and activities.
- Permanent, bank and agency staff covered nursing and healthcare worker vacancies. The service had a recruitment strategy and an employment engagement lead to increase recruitment and retention in the service.
- There were two forensic consultant psychiatrists and two general consultant psychiatrists.
- Physical healthcare was provided by a local GP practice that provided in-reach primary care interventions in to the hospital.
- Staff were up to date with their mandatory training.
- The hospital promoted least restrictive practice and there were systems in place for monitoring and reviewing the use of restraint, seclusion and long-term segregation.
- All patients had a risk assessment, and most patients had been involved in the development of this.
- Staff implemented safeguarding policies to identify and take action about potential abuse.
- The type of service meant that there were necessary safety and security restrictions imposed. Staff were mindful of this and the use of blanket restrictions, when applied, was with consideration.
- The service had implemented a healthy eating, fitness and wellbeing programme. The service was balancing its duty of care to patients who were overweight or clinically obese, with patient choice and least restrictive practice.
- Overall, staff managed and administered medication appropriately. However, we found some inaccuracies in patients' consent to treatment forms, gaps in medication charts, and problems with storage of no longer prescribed and overstocked medication.

Summary of this inspection

- The serviced reviewed and acted upon the high levels of incidents, at a local and corporate level.

Are services effective?

Outstanding 

We rated effective as **outstanding** because:

- Patients had an assessment of their needs which included their mental and physical health and level of risk.
- Care records were patient centred and recovery focused.
- Patients received care from a multidisciplinary team that included doctors, nurses, occupational therapists, psychologists, social workers and healthcare support workers and activity workers.
- The service employed a registered general nurse and healthcare assistant who led on patients' physical healthcare needs. All patients were registered with a local GP.
- There were weekly multidisciplinary team meetings on each ward that involved all disciplines, which the patient was encouraged to be fully involved in. Patients, and were able to see what had been documented in their clinical records since the previous meeting as it was projected on the wall.
- All patients had access to psychological therapies.
- The service had implemented a positive behavioural support programme called RAID (reinforce appropriate implode disruptive). This was a philosophy of care that focused on patients' positive behaviours, strengths and recovery.
- There was a programme of 'real work' opportunities where patients were interviewed, recruited, trained and paid to do jobs in the hospital.
- Patients had access to occupational therapy and had access to at least 25 hours of planned activity per week.
- The service used a variety of tools to measure outcomes for patients.
- Staff received regular supervision and appraisal.
- Effective handovers took place between each shift, and this fed into the daily management meeting where issues and concerns in the service were reviewed by managers.
- There were effective working relationships with commissioners, community based care coordinators and where required the Ministry of Justice.
- Patients had a care programme approach (CPA) or discharge planning meeting every six months.
- The Mental Health Act was implemented in accordance with the code of practice. However, there were some gaps in Mental Health Act consent forms that had not been picked up by the routine audit.

Summary of this inspection

Are services caring?

Good

We rated caring as **good** because:

- Patients were actively involved in their risk assessments and care planning. This included training patients to complete their own risk assessment with staff.
- Interactions between staff and patients were friendly and respectful.
- The majority of patients and carers we spoke with were positive about staff and felt they were treated with respect and kindness.
- The service was meeting targets for actions set by its commissioners around patient care planning and engagement with carers.
- There were patient representatives from each ward and a patients' council that participated in decisions about the service.
- Patients attended governance meetings within the hospital, and contributed to its day to day running and improvement.
- Patients had community meetings which made decisions about the daily running of the ward, and the activities available.
- Patients were provided with a welcome booklet which told them about what to expect in the hospital.

Are services responsive?

Good

We rated responsive as **good** because:

- Complaints were handled effectively.
- There was support for patients with limited mobility.
- When patients were referred to the service they were assessed and if accepted were found a bed quickly.
- All patients had an estimated date of discharge.
- Activity and therapy rooms were available for patients and the wards and within the hospital.
- There was secure storage for patients' possessions including valuables and restricted items.
- There was a range of activities available seven days a week, including during the evenings..
- Patients had access to snacks and drinks at all times of the day and night.
- There were private visiting rooms for families and children.

Are services well-led?

Outstanding

We rated well-led as **outstanding** because:

- The service used a 'dashboard' to oversee key information about patients. This improved patient care because staff routinely reviewed this and acted when they saw gaps. This

Summary of this inspection

included whether patients had had 1-1s with their nurse, if physical health checks had been done and what the results were, and how many incidents and restraints the patient had been involved with.

- The service used information from the dashboard to monitor and improve the quality of care. This was monitored locally, corporately through Partnerships in Care, and by the service's commissioners.
- Arbury Court had targets and development plans agreed with its main commissioner to improve the care of its patients. Information in the dashboard was used to inform commissioners about progress.
- The governance structure included patient representatives.
- The provider used a staff satisfaction tool which showed that staff at Arbury Court were positive about the service and where required felt able to speak out
- Staff were positive about working in the hospital.
- Arbury Court was part of the Royal College of Psychiatrists' quality network for forensic mental health services.
- There was a structure for monitoring quality in the service. This included monitoring of incidents, complaints, and safeguarding and developing the service.
- The provider produced a booklet for staff about how governance worked in the organisation.
- Partnerships in Care had implemented a nurse leadership programme which had been attended managers from Arbury Court.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- All patients using the service were detained under the MHA.
- Staff had completed training in the MHA and its code of practice, and demonstrated an understanding of this in their work with patients.
- Consent to treatment was routinely discussed with patients on and during their admission. Documentation of this was recorded on consent forms (T2s and T3s) and these were attached to the medication charts. However, we found that three of the consent forms that we looked at were not completed in accordance with the MHA code of practice. The provider amended these by the end of our inspection.
- The majority of records we looked at showed that patients had had their rights under the MHA explained to them on admission, and at regular intervals afterwards. However, one record did not record a patient's rights being explained to them for 15 months or if they understood them. This was raised with the provider, who addressed this.
- The service had MHA policies, and a MHA administration team who supported the effective implementation of the Act.
- Patients had access to independent MHA advocates (IMHAs).

Mental Capacity Act and Deprivation of Liberty Safeguards

- There were no patients subject to the Deprivation of Liberty Safeguards (DoLS), and no applications had been made in the last six months. Patients using the service were detained under the Mental Health Act.
- Capacity to consent to specific issues, such as physical healthcare was routinely assessed and discussed in the multidisciplinary team meetings.
- Staff had an understanding and awareness of a capacity.

CQC have made a public commitment to reviewing provider adherence to MCA and DoLS.

Outstanding ☆

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Good

Safe and clean environment

- Each of the wards had an environmental risk assessment carried out, which included a monthly ligature audit. This identified and rated risks, and made recommendations for their removal or management. All patients' bedrooms were single and ensuite. They contained anti-ligature fittings, which included sensor taps in the ensuite toilet and shower. The risk assessments rated some of the remaining risks as 'high' but effectively managed these through observation, security procedures, and individual assessment of patients. All patients had a risk assessment carried out, and plan developed from this to reduce and manage risks.
- Emergency equipment was accessible on all the wards. These included ligature cutters and resuscitation grab bags. The resuscitation equipment included emergency medication, portable defibrillators and oxygen. These were all checked regularly and were complete and in date.
- There were processes for managing safety and security. There were airlocks into the two patient buildings, and then to the wards within the buildings. There was a logging and tracking system for the safe management of keys. Each of the wards had an allocated security nurse each day, and their role included carrying out a security check at the beginning of each shift. New agency or bank staff had an induction when they went to work on a ward. All staff on the wards carried emergency alarms. Staff had radios and mobile phones when escorting patients within the hospital grounds or into the community. There was a security plan, which included emergency agreements with other organisations in the event of a major incident on the unit.
- There were three seclusion rooms in the hospital. These were equipped in accordance with the Mental Health Act code of practice. This included a clock, intercom, daylight, and ensuite with electronically operated door. There was a television and access to outdoor space.
- The wards were clean and maintained. There was a cleaning schedule in place, and this was completed. The hospital had its own team of cleaning staff. The decoration was tired in some areas, but there was a programme of redecoration planned.
- Staff had training in infection control. There were two incidences of methicillin-resistant Staphylococcus aureus (MRSA) at the service at the time of our inspection. An external infection prevention and control nurse had audited the service, and established with a microbiologist that there was no link between the cases. However, the nurse had identified areas for improvement within the service. The wards had access to spill kits to safely clean up body fluids and knew how to use these
- Warrington Borough Council awarded the hospital the highest rating of "5" (very good) for food hygiene following a food safety inspection on 3 January 2014.
- At the time of our inspection, building work was underway to extend the service. There was a plan and ongoing monitoring to ensure that this did not put patients and others at risk.

Safe staffing

Forensic inpatient/secure wards

- The service had 59 qualified nurse posts and 93 health care workers. Of these 15 nursing posts (25%) and 6.5 health care worker posts (7%) were vacant. The vacant posts included staff who were on maternity leave or other long term absence. The service used additional staff to cover enhanced observation and ensure patients were able to have leave and carry out supervised activities. As such there was a core number of staff with additional staff (25%) to cover this. The service used its own staff and bank and agency staff to fill the gaps. Most of the temporary staff had worked in the hospital before and were familiar with the patients and the daily routines of the hospital. There was an induction for all agency staff.
- The service had a recruitment strategy and an employment engagement lead. The service had identified that there was a high turnover of staff. For example in 2015 there were 79 new staff and 49 staff had left. There were multiple reasons for this, but one reason was that new staff left quickly after starting. The employment engagement lead looked into this, and established that new staff did not always find the working environment to be what they expected. Staff were not always aware of the severity of the needs of patients until after they started working here. In response, the service had changed the recruitment process. This included improved information to potential staff, and to test that they were aware of and suitable for the job. There was a retention roadshow in November 2015 and from this developed a prioritised action plan. The employment engagement lead works across the provider's three hospitals in the North West and collates the key themes from his contacts with staff each month.
- Staffing levels were reviewed through the daily management meeting. Once a week the staffing levels for the following week were reviewed to take account of any staff absences and additional staff required. For example for patients' leave and activities. Staffing levels were also reviewed on a daily basis, and staff allocated to wards to take account of events and level of input needed with patients. Staff were moved around the hospital if additional support was required.
- Staff sickness at Arbury Court was low at 2.41%.
- Patient's leave was rarely cancelled because of staff shortages. The taking of leave was monitored through the hospital's patient dashboard. Staffing levels were reviewed to take account of planned leave. An electronic diary was used across the site so that escorted leave was co-ordinated. Patients told us that sometimes leave was postponed if there was an incident, but this was always explained to them and their leave would be rearranged, usually for later the same day.
- There were four consultant psychiatrists, two were specialist forensic psychiatrists and two were general psychiatrists. The hospital had created and was recruiting to an associate specialist post. There was on call consultant cover provided by the hospital, and with its two sister hospitals in the North West. Telephone and inperson medical and management support was available out of hours.
- Physical healthcare was provided by a local GP.
- The service used an electronic training system. This allowed staff to access elearning, record any other training, and to register for any courses they were interested in. Most staff were up to date with their mandatory training. This included safeguarding, conflict resolution, and security. 91% of staff were up to date with basic life support, but only 68% of staff had received training in Immediate life support (ILS). The service had acknowledged this as a problem, and had been delayed following their original supplier withdrawing the number of places. This had been resolved, and staff were attending as places became available. There were ILS trained staff available across the service at all times in order to respond to any emergencies.

Assessing and managing risk to patients and staff

- The service regularly used enhanced observation to support patients. Patients on enhanced observation were routinely reviewed. This was documented in the care records, and monitored through the services 'InCharge Dashboard' system which clearly showed each patients level of observation, the number of times they had been restrained, and if/when they had been secluded or cared for in long term segregation. At the time of our inspection there were 12 patients on one-to-one, two patients in seclusion and five patients on long term segregation. Staff told us they tried to be as unrestrictive as possible, including when patients were in long-term segregation. They engaged patients in

activities, such as crafts, games and exercise. Staff worked with the patient to end the use of long-term segregation as soon as was safely possible. This may involve spending increased periods of time with other patients.

- From 1 March to 21 September 2015 there had been 20 incidents of long-term segregation. 11 of these were on Rosewood ward and eight on Cinnamon ward. Patients who had been secluded or who were in long-term segregation had a care plan that explained the circumstances and plan of care during this time.
- From 1 March to 21 September 2015 there had been 40 incidents of the use of seclusion. Most of these occurred on Delamere ward (21) and Cinnamon ward (14). The use of seclusion was reviewed at the daily management meeting that took place each weekday morning. Seclusion records were completed in accordance with the Mental Health Act code of practice. Patients in seclusion were routinely assessed and the need for continued seclusion reviewed. The records documented why the patient remained in seclusion, and the response to staff attempts to engage them.
- From 1 March to 21 September 2015 there had been 524 restraints that involved 49 patients across all six wards. The most restraints were on Cinnamon ward (230) and Delamere (174). There were 39 prone or face down restraints across five wards, with most on Delamere ward (16) and 9 on both Cinnamon and Oakmere wards. Four of the 39 prone restraints resulted in the patient having rapid tranquillisation, across three different wards (Cinnamon, Delamere and Rosewood). The service was part of an NHS benchmarking peer review scheme with NHS trusts and selected independent providers. When compared with participating medium and low secure services Arbury Court was in the highest quarter for the number of restraints. However, it was in the lowest quarter for the number of prone restraints in low secure services, and around the mean or average for prone restraints in medium secure services.
- Some patients were occasionally restrained with handcuffs when leaving the hospital to go to court or for urgent medical treatment. For example, if a patient required urgent medical treatment and had to go to an accident and emergency department but presented a serious risk of aggression, a member of staff trained to use them would apply the handcuffs. This was 'prescribed' by the responsible clinician, and sometimes the Ministry of Justice. The use of handcuffs was risk assessed on each occasion, and there was a care plan for their use in individual patient's records.
- The service used research-based tools for assessing patient risk. Patients were jointly involved in their own risk assessments. The service had a CQUIN, or target agreed with NHS England, to implement joint risk assessments with patients. This included training for patients in risk assessment and 58% had completed this by the time of our inspection. The service had risk assessed all patients, and they had all been offered a copy of their risk assessment. All staff, including non-qualified, were aware of patients' care plans and how to attempt to de-escalated a situation when a patient became distressed or aggressive. Risk assessments were completed before patients were admitted to the unit. For example, a patient with complex healthcare needs was assessed, and this had been risk assessed and local services agreed a plan of care before they were admitted.
- There was a clear policy outlining how to undertake searches of patients and their property for barred or restricted items. This was risk-based, and staff also carried out random searches in accordance with the policy.
- There was a detailed safeguarding policy which included how to recognise different types of abuse and the action to take. This included the contact details of the local authority. The social worker based at the hospital was the lead for safeguarding, and made most of the referrals. They were the main link with the local authority. Staff on the wards knew how to raise a safeguarding concern, and the hospital recorded and responded to these appropriately, and identified lessons learnt. We reviewed a sample of seven safeguarding records. Most of these were patient-to-patient assaults and had been responded to appropriately. Timely referrals had been made to the local authority, and the necessary organisations informed. For example the commissioners of the service and the Care Quality Commission. Incidents were discussed in the morning management meeting and the multidisciplinary team meetings, and decisions made about potential safeguarding concerns and referrals.

- Medication was supplied by an external pharmacy, who provided three hours pharmacy technician cover each week and reviewed stocks of medication. There was no in house pharmacist or a pharmacist who attended the multidisciplinary team meeting.
- There was a corporate medicines management group. This was due to meet quarterly, but had only met in January and December in 2015. Medication errors were monitored locally and regionally, and reported through the national clinical governance system to identify themes. For example, a medication error occurred that was related to the dispensing of the wrong medication with a similar name. This resulted in the removal of one of the drugs from the stock list. The most common medication errors were staff not signing for medication after it was given, and we identified gaps in recording on the medication charts. These were addressed by the service. Staff were clear about what a medication error was and how to report it.
- Overall, medication was managed and administered appropriately, and weekly audits of medication and prescription charts was carried out. However, we found inaccuracies in patient's consent to treatment forms, and some storage problems. For example, medication that had been stopped was still with the patient's current medication. The provider resolved these issues during our inspection. The dispensing rooms on the wards were small but functional.
- The service routinely submitted information to the nationally recognised Royal College of Psychiatrists prescribing observation for mental health (POMH-UK). In line with other participating services, the most recent audit was conducted 3 years ago. It had last completed the high dose medication audit three years ago.
- Four patients carried out a limited form of self-medication. This was discussed in the multidisciplinary team meeting and there was a checklist completed on a daily basis that ensured this was taken safely.
- There were restricted items and locked doors in the hospital as one would expect in a secure hospital. However, staff told us that within this they implemented least restrictive practice as much as possible. Patients could have individual restrictions and these were documented in their individual care plans and discussed with the patient before implementation. Patients had access to mobile phones but this was risk assessed on an individual basis. As was access to phone charges and electronic devices such as ebooks and tablets.
- Staff told us that blanket restrictions may be implemented for short periods of time but were reviewed. For example, there had been concern that patients were at risk from people outside the hospital. Unescorted leave was temporarily suspended whilst this was investigated which included contacting the police. Additional staff were assigned so that patients could still have escorted leave. Once the concern had been resolved, leave was reinstated. Specific items were periodically banned or restricted on individual wards depending on the patient group. During our inspection pens were not allowed on three of the wards. These restrictions were included in care plans for patients, and reviewed when necessary through the morning management meetings.
- Patients told us about restrictions with regards to access to bedrooms. We found that this varied between wards. On some of the wards patients had limited access to their bedrooms during the day. Staff told us that this was to encourage patients to engage in activities, but they could go to their rooms if there was an activity they wished to do in there other than sleep and isolate themselves. The bedroom corridors were routinely locked during cleaning as a safety precaution.
- The service had developed a healthy eating and fitness programme as many of the patients were overweight or clinically obese. The service had introduced healthier snacks and meals, and staff were working with patients about promoting fitness and making healthy choices. There were mixed views from patients about the fairness of this. Some patients were positive about the food and the healthy eating initiatives. Others thought the food was very poor and that snacks were limited. Staff told us that patients were encouraged to eat healthily but were not forced to do so. Some patients agreed that this was the case but others did not and said they did not have a choice about the food they ate. There were differences between how this was implemented on each of the wards. All patients had access to food and drinks, and had their own locked snack cupboard. The kitchens were locked on most of the wards, but were open on

two of the wards where patients were further along the recovery pathway. The service was balancing its duty of care to patients who were at additional risk of long term health conditions such as obesity, heart related problems and diabetes, with patient choice and least restrictive practice.

Track record on safety

- There were 17 serious incidents recorded between November 2014 and August 2015. Of these five were recorded as a "type 1" which is the most serious type of incident and includes severe harm of a person. Cinnamon ward had six serious incidents, which was the highest of all the wards. The incidents related to patient self-harm, physical assault, allegations of sexual assault and racial abuse. These were appropriately investigated and responded to.
- Most serious incidents were related to self-harm. The service had introduced dialectical behaviour therapy in June 2015, which is a research based therapy with recognised benefits for people who self-harm. This had been piloted with a small group of patients, and was due to be rolled out across the service.

Reporting incidents and learning from when things go wrong

- Incidents were recorded electronically and followed a standard reporting template. This tracked and monitored incidents, and was linked to the electronic patient record. All permanent and bank staff had access to the electronic reporting system. Agency staff recorded incidents on a paper form, and this was manually added to the system. Investigations were carried out, and each incident investigation included recommendations, lessons learnt and evidence of how these had been shared with the wards. We reviewed a sample of nine incident records from October and November 2015. These had all had a detailed investigation. The provider confirmed that there were high levels of incidents reported, but that this was because any incident where a member of staff was required to place hands upon a patient, such as to gently guide them, was classed as a restraint.
- Staff were clear about the need to be open and report incidents.
- From 15 September 2014 to 14 December 2015 the highest cause of injury (36.8%) was from physical assault by a patient. 119 of these were assaults on staff, 21 to other patients and six to others. Staff supported patients following incidents. Staff were offered support and debriefing after incidents by either managers or psychologists. Staff told us that this was helpful, but it did not always happen quickly enough. There was a leaflet for staff that explained what to do and the support they could get following an incident if they had been hurt by a patient.
- Information about governance including incidents was accessible to staff on the hospitals intranet, called 'ward to board'. A monthly email was sent by senior staff throughout Partnerships in Care informing staff of any incidents that had occurred, and any feedback or change to practice following this.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Outstanding ☆

Assessment of needs and planning of care

- We looked at fourteen care and treatment records.
- A consultant psychiatrist assessed patients prior to admission which included a risk assessment. Discussion then took place with the multidisciplinary team about the suitability of the patient for admission, and the care they could offer. Patients had a detailed physical and mental health assessment on admission to the hospital. The service employed a registered general nurse and healthcare assistant who led on the physical healthcare needs of patients. A local GP provided services to all the patients as necessary.
- The service used an electronic patient record. Information from this fed into a 'dashboard' which was used to monitor patient care, and to inform the organisations monitoring and governance. Paper records and correspondence with other organisation was scanned and uploaded into the electronic patient record.

- All patients had care plans that were recovery orientated and person centred. They included the patient's point of view. Part of this included a description of the help and support that patients needed from others such as ward staff or the physical health nurses. There were detailed risk assessments. Care plans were up to date and regularly reviewed.

Best practice in treatment and care

- All patients had access to psychological therapies. The service had a clinical dashboard which was used to monitor the time patients had planned for psychology and how much they received. The service had introduced dialectical behaviour therapy in July 2015 for five patients, and was intending to implement this across the rest of the service. Patients had access to 1-1 and group sessions with psychologists which included mindfulness.
- The service had implemented a positive behavioural support programme called RAID (reinforce appropriate implode disruptive). This was a philosophy of care that focused on patients' positive behaviours, strengths and recovery. 70% of staff were trained in the approach. Staff told us that the programme aimed to reduce the use of restraint and seclusion by using diversional and distraction techniques.
- There was a programme of 'real work' opportunities. Patients were interviewed, selected, trained and paid to do jobs in the hospital. These included housekeeping and working in the hospital shop. Patients and staff were positive about this, and clear it was a real experience of work for patients that was clinically indicated and recovery focused.
- All patients were assessed by the occupational therapist, and had at least 25 hours of planned activity per week. This was reviewed weekly, and if this target was not met it was flagged in the clinical dashboard. The reasons for this would be discussed. For example, there may be service issues or the patient may not want to engage. Actions would be taken to try and address this.
- The service used a number of rating scales and outcome measures. These included HONOS which was reviewed at the six-monthly care programme approach meetings, HCR-20 a forensic risk assessment tool, and START a risk assessment tool completed on admission by the primary nurse and then reviewed in the multidisciplinary team meetings. The occupational therapists used the model of human occupation screening tool. It was adapted to meet the needs of mental health patients and was used as an engagement tool with patients. The occupational therapists used evidence based interventions which included the Addenbrooke cognitive assessment, the functional living assessment scale, and the Barthel index of activities of daily living.
- During 2015 the hospital carried out audits in least restrictive practice, longer term management of self-harm, patient observation, data protection, seclusion, and medication management. Action plans were developed and implemented from these audits.
- A physiotherapist worked in the hospital for half a day per fortnight, and provided specific interventions identified by the occupational therapists. Podiatrists and opticians visited the unit when required. Patients were referred to the relevant medical specialists for assessment and treatment when required, and were supported to attend hospital appointments outside Arbury Court.

Skilled staff to deliver care

- Patients received care from a range of staff. This included consultant psychiatrists, nurses and support workers, occupational therapists and activity workers, psychologists and a social worker. A pharmacist technician reviewed medication supplies each week, but there was no direct pharmacy input to patients or to the multidisciplinary team meetings. There were psychologists working on each ward, and all patients were offered mindfulness and stress management. The lead occupational therapist led a team of 14 occupational therapists, who were based on specific wards. They also had an education facilitator, two salon workers, and 1.6 sports facilitators, There were four activity coordinators who provided activities across seven days and included evenings.
- Nursing staff and healthcare support workers had supervision every six to eight weeks. These were recorded and actions outlined. The supervisor and supervisee each retained a signed copy of the document. Staff had supervision 'passports' where they recorded informal supervision sessions or assessments.

Medical staff had continuing professional development sessions with their colleagues across the North West hospitals once a week. The occupational therapy and psychology staff had regular supervision.

- There were effective recruitment processes in place. Each member of staff had an electronic staff record. The necessary checks were carried out when staff were recruited, which included references, an interview, a disclosure and barring service (DBS) check, and a medical review. The human resources department monitored professional registration, and identified when renewals were due. New staff completed a two week induction programme. Most staff had had an annual appraisal, or were new staff. New staff had a probationary period and had an appraisal as part of their six-monthly review.
- The service had processes for monitoring and managing staff absence. This included supporting staff who had extended periods of sickness, and managers dealt with this fairly and reasonably. There were processes for managing grievances and disciplinary action, and we saw examples of these in practice.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings took place every week on each ward and were attended by medical, nursing, psychology, occupational therapy and social work staff. Individual patients were reviewed and attended the meeting every four weeks. The multidisciplinary team meetings showed effective multidisciplinary working and involvement of patients in their care. Records were projected on the wall so that patients and all staff could see what had been written. During the meetings patients and staff were asked their views, assessments were reviewed where necessary, and leave and activities were discussed. They were recovery focused and reinforced patients strengths and moving forward, whilst risks were reviewed. From the meeting there were action plans which included who was responsible for carrying out each of the actions and the due date for completion.
- Two of the five multidisciplinary team meetings we attended did not have a medical staff there as the consultant was on leave. The meeting was chaired by a senior psychologist and each patient's care was discussed. Staff confirmed that urgent medical cover was provided by another consultant psychiatrist. However, some patients said they did not see the point of attending the meeting if the consultant was not there. We did not see any evidence that patients' needs had not been met because of the consultant's absence. However, there were some areas that could not be discussed because they required medical or responsible clinician input. For example, medication changes or letters to the Ministry of Justice.
- Care programme approach (CPA) or discharge planning meetings took place for each patient every six months. These were attended by the patient and the multidisciplinary team, and usually staff from the patients' home area and family where possible. The service worked with other organisations which included the Ministry of Justice, care coordinators and commissioners from other areas and specialist services when planning toward discharge.
- There were handovers between shifts, which included an action sheet so that it was clear what needed to happen during the shift. During this meeting staff were allocated to each of the wards. Following this there was a daily handover meeting with senior staff across the service. This had a standing agenda, and included a discussion of any significant events which included incidents, safeguarding and seclusion and long term segregation. It also discussed occupancy and any potential admissions or discharges. Complaints and the dashboard were scheduled to be reviewed once a week on fixed days, so that it was reviewed regularly by the management team and any gaps identified and addressed. Managers and lead clinicians for nursing, psychiatry, psychology and social work and occupational therapy attended the meeting.

Adherence to the MHA and the MHA Code of Practice

- Most staff (86%) had had training in the Mental Health Act (MHA) and its code of practice. Staff demonstrated an understanding of the Act and its code of practice in their work with patients. Overall, the MHA was effectively administered. The service employed MHA administrators who ensured the paperwork was correctly maintained and updated. This included for patients who were subject to Ministry of Justice restrictions. The electronic patient record flagged up

when renewal of rights, or an expiration of section or consent was due. This helped staff to ensure they were meeting their responsibilities under the Mental Health Act.

- Capacity to consent to treatment was routinely discussed with patients on and during their admission. Discussions about capacity to consent were recorded on the electronic patient's record. Documentation of this was recorded on consent forms (T2s and T3s) and these were attached to the medication charts. However, we found that three of the consent forms that we looked at were not completed in accordance with the code of practice. The provider amended these by the end of our inspection. There were regular Mental Health Act audits, but these had not identified this problem.
- The majority of records we looked at showed that patients had had their rights under the MHA explained to them on admission, and at regular intervals afterwards. However, one record did not record a patient's rights being explained to them for 15 months or if they understood them. This was raised with the provider.
- Patients had access to an independent Mental Health Act advocate. Information about advocacy service was on display, and patients told us they were aware of the service and some had used it.

Good practice in applying the MCA

- All patients at Arbury Court were detained under the Mental Health Act. There had been no Deprivation of Liberty Safeguards (DoLS) applications.
- Capacity was routinely discussed and assessed in the multidisciplinary team meetings. Staff had an understanding and awareness of capacity issues, which included with regards to consent to physical healthcare treatment.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

- The interactions we observed between staff and patients were friendly and respectful. Staff and patients engaged with one another, and we observed one to ones, activities, and patients going out. The majority of patients we spoke with were positive about staff and felt they were treated with respect and kindness.
- The hospital carried out an annual patient satisfaction survey and a carers satisfaction survey in January and February 2015. Of the 51% of patients who responded, 89% rated their overall care as good, very good or excellent, and 11% thought it was fair or poor. The service used the 'friends and family test' which was currently at 100%. This meant that all patients who responded would recommend the service to friends and family.

The involvement of people in the care they receive

- On admission patients were given a welcome booklet. This explained how the hospital worked, treatments and therapies available, the roles of staff, how to complain and other pertinent information about day-to-day life on the ward such as washing clothes and contacting a GP.
- Patients were actively involved in their care. The hospital had plans and targets agreed with its commissioners for involving patients in their risk assessments. We saw that the service was meeting its targets. Staff carried out collaborative risk assessments with patients. 58% of patients had had training in this, as part of an ongoing training programme. In the multidisciplinary team meetings patients were involved in discussions about their care. The care records were projected on the screen so that patients could see what was being written. The hospital also had targets agreed with its commissioners to engage with carers. This included the development of a strategy for carer involvement.
- Patients said they were able to have visitors to the unit. Some patients did not like being placed so far away from their homes and families, but understood this was because there were no beds available nearer to home. The carers we spoke with were mostly positive about the care and support both they and their relatives received. We saw examples of where carers had been unable to attend the multidisciplinary team meeting their queries had been discussed at the meeting, and they had had feedback from this.

Outstanding ☆

Forensic inpatient/secure wards

- There were weekly community meetings on each of the wards. Patients raised concerns and made decisions about issues on the ward. This included changes to the timetable on the ward, and decisions about activities. For example, patients on Appleton ward had requested a visit to a large shopping centre and to a garden centre, and this had taken place. Patients had also requested an exercise bike which they now had one. In the approach to Christmas, staff and patients discussed and agreed the timing and menu for Christmas meals. Patients had requested adjustments to the times of smoking breaks, and the ward had adopted this.
- Each ward had a patient representative. Regular patients' council meetings took place every one to three months. The council was involved in decision making about the service. Patient representatives attended meetings at the hospital, which included the ward planning and developmental team meetings, the redevelopment meetings, and the clinical governance meetings.
- Patients were part of interview panels for new staff.
- The hospital sent out a newsletter with information about fundraising events, and the building work and development that was taking place on the site.
- Patients had access to a general and a Mental Health Act advocacy service. Information about the advocate was on display and this included who they were and how to contact them. There was an advocacy service provided to the unit. There was information about the service on display. Patients told us they were aware of this, and some patients had used the service.
- The service used 'my shared pathway', which was a tool for involvement patients in their care planning in a user-friendly format. The hospital was in the process of installing a new electronic system. When completed this would enable patients to electronically access information about themselves. For example appointments, care plans and terms of leave. There were computers for patients to use on each of the wards.

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

Good

Access and discharge

- The average bed occupancy rates from March to September 2015 were between 96.% and 99% across all six wards. The wards were usually at or near capacity. During this period the average bed occupancy on each of the wards was one patient below its maximum. Patients were usually admitted from prison or court, or other secure services.
- The hospital admitted patients nationally, which included people from England, Wales and Northern Ireland. The service had a target to assess patients within a week of referral, and if they were deemed suitable to admit or identify a bed for them within a week of the assessment. These targets were met on most occasions.
- There was one person whose discharge was delayed between 1 April and 29 September 2015, and this was outside the control of the hospital. Patients had a care programme approach or discharge planning meeting every six months. All patients had an estimated discharge date recorded on their file. The patients we asked about this were aware of their expected discharge date.

The facilities promote recovery, comfort, dignity and confidentiality

- All patients had single rooms with an ensuite shower, toilet and sink. All the wards had lounges, quiet rooms, kitchens for making drinks and snacks, outdoor space and activities. There was internet access for patients on each ward.
- Visitors were not usually allowed on the wards. There were private rooms on site where patients could meet visitors including children.
- Patients had lockable storage in their rooms and said that their belongings were safe. There was additional lockable storage for valuables, and for restricted personal items such as aerosols and razors.
- There were allocated smoking times, and patients were provided with help to stop smoking.

Forensic inpatient/secure wards

- There were shared facilities such as an activities of daily living kitchen, art and craft rooms, a dedicated music room and a gym. There were four activity workers who provided activities across the hospital seven days week. There were two sports facilitators who supported exercise and physical activities, and two salon workers who provider hairdressing, beauty and pamper sessions for patients. Patients were supported to go outside the hospital and this included shopping and to the cinema. Patients requested what they wanted to engage in through the community meetings. The service had run a number of fundraising events for charity, which included their annual sports day which families and carers were invited to.
- The service had a shop that was staffed by patients and opened five days per week. It sold at-cost snacks, toiletries, and other items patients requested.
- Patients were positive about 'pets as therapy' that was provided by the hospital dog, guinea pigs and rabbit.
- There was a payphone on each of the wards. However, most patients had their own mobile phones. Access to this was risk assessed by staff.
- Patients had access to drinks and snacks. There was a four-week rolling menu. A food survey had been carried out to give patients a say in the food that was provided. The menus used a red and green colour code to indicate healthy food choices.

Meeting the needs of all people who use the service

- The service supported patients with limited mobility. For example, there were patients who had a mobility scooter or were being supported to get one, to improve their access to the community. The occupational therapists carried out assessments of patients with limited mobility, and any support equipment they required.
- The visiting rooms were not easily accessible for a person in a wheelchair. Improved disabled access had been included in the plans for the new unit that was being built at the time of our inspection.
- Staff told us interpreters were available if required. Patients had access to food that met their dietary, religious or ethnic requirements.

Listening to and learning from concerns and complaints

- From November 2014 to October 2015 there had been 97 complaints made to the service. Of these 53 (55%) had been upheld. The monthly log of complaints showed that from January to October 2015 the average number of complaints was just over seven per month, with the fewest being three and the highest 12 in any one month. Many of the complaints were regarding loss or damage to property. Lessons learned and action taken from this including implementing measures so that patients took ownership of their belongings, and the service had provided lockers for patients. Other issues included patient-to-patient assaults, and staff attitude. Action had been taken to address the immediate problem whilst it was investigated. A summary of complaints was completed each month which included location, outcome, recommendations and outstanding actions.
- Information about how to make a complaint was included in the welcome pack for patients, and was on display. The most recent patient survey was in January 2015. From this, 92% of patients said they knew how to make a complaint. Patients told us they could complain either through the complaints process or directly to staff. A complaints officer supported patients with complaints.
- There was a complaints policy, and a guide for managers in how to deal with complaints effectively. Complaints were discussed and monitored in the daily management meetings.
- Patients raised concerns and complaints in the community meetings, where the outcome of some complaints was also discussed. On Appleton ward they had 'you said, we did' information on display. This showed action that had been changed in response to patients' comments. For example a new toaster had been bought, and a washer fixed. Some patients were positive about how their complaints had been responded to, but others did not feel anything changed as a result. Complainants could appeal if they were not satisfied with the response to their complaint.
- There had been allegations of bullying amongst patients. The service had identified this and run sessions with patients to reduce this, with apparent

success. They had identified that this was a potential problem again on some of the wards and had planned to run some more sessions. We saw that this was discussed in a community meeting.

Are forensic inpatient/secure wards well-led?

Outstanding ☆

Vision and values

- The Partnerships in Care values were published on its website, and were on display on the wards. These were respecting staff, patients, their families and communities; caring for ourselves, our patients, our customers and communities; uncompromising integrity, respect and honesty; working together with everyone; and taking quality to the highest level. Staff reflected the values in their views and behaviour throughout our inspection.

Good governance

- The hospital had systems that ensured staff were up to date with mandatory training, supervision and appraisal. There were pressures on staff, created by the needs of and the turnover of staff. The service managed this through daily and weekly reviews of operational staffing on the wards. There was an ongoing recruitment plan to address the recruitment of permanent staff, which included looking at why staff left and how to improve retention and satisfaction.
- The hospital had systems for logging incidents, concerns and complaints, so that these were investigated and action taken to prevent their reoccurrence. This was monitored at a local and corporate level.
- The service produced a booklet for staff that explained how governance worked within the organisation. This included how the various meetings, regulations, stakeholders, commissioners and quality monitoring all worked together to improve services.
- Arbury Court had a local clinical governance structure that was part of the wider Partnerships in Care corporate governance structure. At Arbury Court the monitoring of the service took place through the hospital operational and clinical governance meetings and the regional managers' clinical governance meeting. Ward and managers meetings, such as the patient community meetings and daily management meetings, fed into this. As did specific area groups that included security, health and safety, and the staff communication and consultation group. Arbury Court followed the corporate Partnerships in Care quality and benchmarking cycle. This included feeding its local audits into the corporate database, so that findings were monitored and compared against other hospitals.
- The provider used "quality accounts" which is a system for healthcare providers to report on quality to local communities and stakeholders by monitoring patient safety, the effectiveness of services, and patient feedback about the care provided. This process is well established in NHS trusts. It included the objectives for the year and CQUINS or targets agreed with NHS England. Commissioners of the service set these development targets for the hospital called CQUINs (commissioning for quality and innovation).
- The provider had specific CQUINs to improve the care of patients in its services. For example, the CQUINS for Arbury Court included providing outcomes regarding the national audit of schizophrenia. This CQUIN focused upon reducing premature mortality in people with severe mental illness. This checked to see if patients had received a physical healthcare check. For the most recent two quarters available, they showed that 63 and 66 patients at Arbury Court had been audited, and of these 58 patients had received a physical health check for each quarter, and 9 and 8 had refused. This meant that all patients had been offered a health check, and most patients had had one. There were care pathways for other conditions included within the CQUIN for asthma, epilepsy, diabetes, smoking and alcohol use.
- The service had a 'dashboard' which was a live system for each ward, and included specific information for each patient. This helped the ward manager in their management of the ward and information in the dashboard was accessible to all ward based staff. It clearly identified key areas of patient care and highlighted any gaps or where items were due for review. This included risk assessments, physical healthcare checks, levels of enhanced observation and the use of seclusion, restraint, and how many and at

what level of incident patients had been involved in. Estimated discharge and care programme approach dates were also included. The dashboard included the 'meaningful week', which monitored each patient's activities, leave, and sessions with their nurse and psychologist. These included recording the reason why activities or groups had not been attended by each patient. This overall dashboard showed essential standards were in place.

- Each hospital within Partnerships in Care had a health and safety advisor with relevant health and safety training, in addition to experience of the clinical environment. Each ward had a health and safety champion who attended a monthly meeting on site and ensured action plans were implemented and reviewed. Each ward had a planning and development team who reviewed all ward incidents. This group was made up of medical and nursing staff, a patient representative, housekeeping and maintenance staff, and the health and safety advisor. The health and safety advisor offered advice and support and took action where required. The monthly health and safety meeting at Arbury Court fed into the corporate governance meeting, so there was an overview of health and safety across Partnerships in Care. National alerts were sent to the health and safety advisor, who disseminated relevant information to the wards.
- There was an up to date corporate and local risk register.

Leadership, morale and staff engagement

- The provider used a staff satisfaction tool called the 'Culture of Care Barometer'. The most recent staff survey was in 2014. This compared staff at Arbury Court with staff in Partnerships in Care overall. This showed that staff responded slightly more positively at Arbury Court. There were 30 questions which staff were asked to rate on a five-point scale from strongly agree to strongly disagree. The overall findings showed that most respondents were positive about the service across most questions. Most responses were over 70% which included for quality of service, job satisfaction and motivation, leadership and management, team work, learning and development. Personal performance and opportunity was at 66.9%. The service developed an action plan from this, and had identified key areas to work on which included recognising good performance, responding to staff concerns and opportunities for career development.
- Most of the staff we spoke with were positive about working at Arbury Court, and said that staff worked together well. Staff were provided with information about how to raise concerns or whistleblow. Most staff we spoke with said they felt able to use their own initiative, and to raise any concerns they had.
- The staff sickness rate over a 12-month period was 2.41%.
- Partnerships in Care had implemented a nurse leadership programme, which had been attended by managers from Arbury Court. Most staff were positive about managers within the hospital. The managers were spoke with were positive about the support they received.

Commitment to quality improvement and innovation

- Commissioners of the service set development targets for the hospital called CQUINs (commissioning for quality and innovation). The provider had specific CQUINs to improve the care of patients in forensic services. These included completing collaborative risk assessments with patients, improving physical healthcare, and implementation of a quality dashboard to give commissioners assurance that services were safe and effective. CQUIN activity and compliance was monitored by a series of quality dashboards. These were completed and reviewed at Arbury Court, fed up to through the corporate governance structure, and reported to the main commissioners NHS England. The dashboards were used by ward managers and at multidisciplinary team meetings to ensure that patients' needs were met and that staff were clear what targets were in place for measuring quality. For example, by ensuring that risk assessments had been reviewed, planned activity and leave had taken place, and physical observations monitored. If this had not occurred, then the system flagged this up and action was taken.
- The hospital was part of the Royal College of Psychiatrists' quality network for forensic mental health services. This meant that Arbury Court was assessed by its peers against a set of standards developed by the

Forensic inpatient/secure wards

college. In turn staff from Arbury Court visited similar hospitals to carry out assessments on them. The service was part of the review cycle that looked at low secure and medium secure standards. The most recent review was carried out in October 2015. This highlighted good practice in patient engagement, 'real work' such as housekeeping, and the patients' council. Recommendations for improvement included updating of some of the facilities, reviewing the gender mix of staff at night, and reviewing the rules regarding snacks and bedroom access. The service included these findings in its ongoing monitoring and improvement processes.

Outstanding practice and areas for improvement

Outstanding practice

- Patients received training in risk assessments, so that they could actively participate in their own risk assessment process, and in how they could work with staff to manage these risks.
- Patients were an integral part of the monitoring and governance of the service. Each of the wards had a patient representative who put patient's views forward at the patients' council. Patients also attended meetings in the hospital which included the clinical governance meetings.
- The service used a 'dashboard' to oversee key information about patients. This actively impacted on patient care as it was routinely reviewed by ward staff and the multidisciplinary team, and any gaps were acted upon. This included whether patients had had 1-1s with their nurse, if physical health checks had been completed and what the results were, and how many incidents and restraints the patient had been involved with. This information was also used for monitoring at a local and corporate level, and was used to inform commissioners if the service was meeting its CQUIN targets.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that consent to treatment forms reflect the medication a patient is taking and the code of practice. MHA audits should be able to identify any gaps or errors in the forms.
- All patients should have their rights under the Mental Health Act explained to them routinely, even when they have been in hospital for an extended period of time.
- The provider should review medical cover in multidisciplinary team meetings when regular consultant psychiatrist is not available.
- The provider should ensure medication is managed, stored and disposed of correctly.