

Nottinghamshire Healthcare NHS Foundation Trust

Rampton Hospital

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RHA04	Rampton Hospital	Emerald Ward, Jade Ward, Ruby Ward, Alford Ward	DN22 0PD

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare NHS Foundation Trust. 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.

Where applicable, we have reported on each core service provided by Nottinghamshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare NHS Foundation Trust.

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

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

Summary of findings

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Summary of findings

Overall summary

We carried out an unannounced focused inspection and found;

- The trust had an observational policy to maintain patient safety. The policy was not followed consistently, therefore the system of conducting observations was not effective and placed patients at risk. This is a breach of regulation 17 relating to governance systems and processes. We will issue a warning notice. We found that not all staff had signed that they had read the observation policy. The closed circuit television footage was not audited to check that the observation policy was being implemented.
- We found instances of observations being carried out late, there were staff signature gaps in the observation records reviewed, pre-printed times on observation forms were used, therefore, observations were not recorded at the time that they were actually done.
- The responsible clinician had not consistently recorded the review of frequent observations on a daily basis.
- Not all staff had not received further training following recommendations and learning from serious incidents.

- Staff shortages led staff to move from wards to assist other wards. Staff shortages also affected patient activities; particularly on the wards.
- Sickness rates were high on women's wards.
- Patients reported spending long periods locked in their rooms.

However;

- The hospital was responsive in implementing an action plan to improve observation practice on the 1 April 2016. It was however too soon to evaluate its impact.
- Staff received counselling and debriefings following serious incidents.
- Staff recruitment was occurring and newly qualified staff had a six week preceptorship programme.
- Clinical supervision was in place for staff.
- Patients reported feeling safe and that staff were respectful and caring.
- Patients had care plans in place and had received copies.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We found that;

- In the period 2014/2015, 674 attempts of self-harm occurred in the women's services. Between January and December 2015, 24 out of 32 suicide attempts occurred in the women's services. A high level of observations were required on the women's wards to maintain safety.
- All staff on wards had not signed that they had read the observation policy. Audits of the closed circuit television footage to check that the observation policy was implemented had not occurred.
- We found on closed circuit television footage reviewed, instances of observations being carried out late. Observation records had not always been signed. All observations were carried out on the quarter of the hour. Some observation forms had pre-printed times therefore observations were not recorded at the actual time.
- Records reviewed did not demonstrate multidisciplinary discussions taking place about observations.
- Staff were moved from wards to assist other wards due to staff shortages. This meant that wards did not operate with their full core set of staff.
- Sickness rates on the women's wards were high, ranging from 12 to 21%. There were 11 staff off sick at the time of our visit to Emerald ward.

However;

- The hospital introduced an action plan to improve observation practice on the 1 April 2016.
- Wards had anti ligature features, staff were aware of ligature risks and mitigation occurred through supervision of patients and observation.
- Staff followed high security procedures to maintain staff and patient safety.
- Wards had well maintained furnishings and were clean and tidy.
- Staff mandatory training compliance in first aid, suicide awareness and self-injury were high.
- Staff and patients received debriefings following serious incidents and ongoing support.

Are services effective?

We found that;

Summary of findings

- Records reviewed showed patients had care plans in place. Physical health monitoring checks and annual physical healthcare checks took place.
- Registered adult nurses visited the wards to provide physical healthcare advice and support.
- Audits were carried out of care plans, one to one sessions, treatment risk information management systems, and restrictive practice.
- There was good adherence to the Mental Health Act.

Are services caring?

We found that;

- Patients felt safe on the wards and staff were respectful and caring.
- Staff understood the needs of patients.
- Patients had copies of care plans.
- Patients had a “distress” signature book in which recorded how they wished to be treated during periods of distress.

However;

- Patients were concerned they spent too much time in their rooms.
- Patients reported activities being postponed due to staff shortages; nurses confirmed that staffing affected ward activities being provided.

Are services responsive to people's needs?

We found that;

- Four patients had been waiting for over a year to go to a less secure environment.
- The uptake of activities was low. Patients had their own individual activity programmes, an education centre provided activities, however staff and patients stated staffing levels affected the activities on the wards.

However;

- Patients had keys to their own lockers and bedrooms based on risk assessments.
- Patients had weekly one to one sessions with staff.
- Notice boards provided information about the ward routine to assist patients.

Are services well-led?

We found that;

Summary of findings

- Staff had access to counselling and clinical supervision following incidents.
- Newly qualified staff had a six week preceptorship programme on commencing employment.

Summary of findings

Information about the service

Nottinghamshire Healthcare NHS Foundation Trust achieved foundation status in 2015. Rampton Hospital is part of the trust.

Rampton Hospital is a high security hospital which offers services to patients who suffer from mental disorders and have dangerous, violent or criminal tendencies. On average, patients stay in the hospital for approximately seven-and-a-half-years but a very small number are likely to remain at the hospital for the rest of their lives.

Every person admitted to the hospital must fulfil two criteria. Firstly, detention occurs under one of the classifications of mental disorder, as defined by Section 1 of the Mental Health Act 1983. These are mental illness, mental impairment, severe mental impairment and psychopathic disorder. Secondly, patients admitted must need to be in a high security hospital. Patients thought to have either a personality disorder or a mental impairment must also be treatable. Patients are mainly admitted from prison and from medium secure units.

Rampton Hospital was registered with the CQC in 2010 to provide;

- assessment and treatment of people detained under the Mental Health Act 1983
- treatment disease , disorder and injury
- diagnostic and screening procedures

The chief executive of Nottinghamshire healthcare NHS foundation trust, Ruth Hawkins, is the responsible individual for these services.

CQC inspected Rampton Hospital in 2013 and found that it met the standards reviewed. CQC undertook a comprehensive review of the trust in May 2014. The forensic service, of which Rampton is a part of, was rated overall as good for safety, effectiveness, care, responsiveness and for being well led.

A total of 24 Mental Health Act monitoring visits took place between 1 April 2015 to 31 March 2016. The trust submitted action plans following visits. A common theme emerging from visits related to staffing issues. The trust had a robust recruitment plan in place with the aim of over recruiting to staffing vacancies by December 2015. The trust confirmed to the CQC that it had achieved this target.

A national high secure service for women forms part of Rampton Hospital.

We visited;

- Emerald ward; a 12 bed purpose built intensive care for vulnerable women primarily with learning disabilities and personality disorders. The ward was divided into A and B sides with six bedrooms each side
- Jade ward; a 12 bed female assessment and treatment ward for patients with a primary diagnosis of mental illness
- Ruby ward; a 14 bed female treatment ward for patients with a primary diagnosis of personality disorder
- A Mental Health Act visit was carried out on Alford ward; a high dependency 16 bed rehabilitation and treatment ward for men with complex mental illness

Our inspection team

Team leader ; Surrinder Kaur CQC inspection manager

The team that inspected Rampton hospital was comprised of five CQC inspectors and three MHA reviewers over three days.

Summary of findings

Why we carried out this inspection

We carried out a focused inspection on the three women's wards and a male ward at Rampton Hospital following coroners concerns about serious incidents.

The focus of the inspection related to ;

- staffing
- observations
- serious incidents

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 these services. The police and coroner shared information with us.

During the inspection visit, the inspection team:

- visited Emerald ward on the 18 March and 11 April 2016, Jade and Ruby wards on the 11 April 2016. A Mental Health Act Reviewer visited Alford Ward on the 29 March 2016
- we looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 20 patients who were using the service
- spoke with 17 members of staff which included the managers or acting managers for each of the wards, nurses and support workers
- looked at 18 treatment records of patients
- looked at six medication records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- All patients we spoke with said that they felt safe on the wards.
- Patients praised staff highly in the care they provided and described them as "brilliant" teams.
- Patients stated that staff shortages led to the postponement of activities off the ward such as the gym, social functions and visits to the activity centre.
- Patients confirmed that advocacy services visited the ward and they could speak to them if they wished.

Good practice

Patients had a distress signature book to record their strengths and areas of development. It also recorded how patients wished to be treated when they became distressed.

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

- The provider must monitor and improve the observations of patients and records made.

Action the provider **SHOULD** take to improve

- The provider should ensure it has adequate staff in place to provide care, treatment, and activities for patients.

Nottinghamshire Healthcare NHS Foundation Trust

Rampton Hospital

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Emerald Ward	Rampton Hospital
Jade Ward	Rampton Hospital
Ruby Ward	Rampton Hospital
Alford Ward	Rampton Hospital

Mental Health Act responsibilities

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

- Detention papers reviewed and appeared to be in order
- The assessment of capacity and discussion around medication consent was recorded in the patient notes reviewed.
- Medication charts had authorised treatment certificates attached in order that staff knew under what legal authority the administration of medication occurred.
- An independent mental health advocate (IMHA) attended the ward and community meetings to support patients exercising their rights.
- Records showed that patients had received information about their rights; including access to IMHA. Staff repeated the information at intervals.
- Patients told us they understood their right to appeal to a MHA tribunal. Section 17 leave was authorised on standardised forms which included risk assessments.
- Night-time confinement occurred in accordance with the with the high security psychiatric services (arrangements for safety and security) directions 2013.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The ward layout enabled staff to observe the main lounge areas and corridors from the nursing office to maintain safety. On Alford ward one of the bedroom corridors was T shaped. There were no fish eye mirrors (that enabled views around corners) so it was not possible to observe some bedrooms from the main corridor. Staff managed this by carrying out observations.
- On Ruby ward, one of the patient bedrooms had a camera enabled function for use in exceptional circumstances, so that staff could monitor from outside of the bedroom. This enabled patients to have a degree of privacy and dignity. Communal and corridor areas had closed circuit television cameras (CCTV) positioned to record activity. Live CCTV activity monitoring occurred in the nursing office if required. CCTV footage was reviewed when incidents or complaints occurred.
- The hospital followed the high security psychiatric services (arrangements for safety and security) directions 2013 to maintain staff and patient safety. A policy for the management security keys due for review in April 2018 was in place. We observed staff following security procedures. Staff confirmed that the allocation of a staff member occurred on each shift to monitor a range of security checks on the ward including room searches.
- Wards had well maintained furnishings and the environments appeared to be clean and tidy.
- Hand gel was available for staff to use in the ward areas as part of infection control principles.
- All wards were single sex wards and therefore complied with same sex accommodation.
- One patient expressed concern about bullying between patients when staff were not present to witness it and that community meetings did not discuss bullying. Community records showed that bullying had not been discussed.

- A health and safety risk assessment policy was in place and was due for review in 2017. The policy required three staff of specific designations to carry out the assessments. In the forms reviewed this had not occurred. The assessor and manager signatures were missing from the assessments.
- We undertook a review of four environmental and ligature assessment forms. Annual assessments occurred of the communal areas, bathrooms, and bedrooms using a basic assessment tool. The forms did not reflect the trust policy of assessing all rooms on the ward in turn. We also viewed action plans in place that described how risks would be mitigated and managed. The risk assessment form ticked that the results were communicated to ward staff and senior managers and if the risks were to be reflected in the directorate risk register. However, dates of when and how this was done were not recorded.
- Staff were aware of the ligature assessments and gave examples of anti-ligature features such as flexible coat hooks and moulded radiators on the ward. On Alford ward, the communal bathroom areas had potential ligatures, these had been risk assessed. On Ruby ward, there were window catches in the communal areas. Staff told us they managed these ligature risks through supervision and observation.
- Staff carried alarms to respond to emergencies and incidents.

Safe staffing

- Nottinghamshire Healthcare NHS Foundation Trust had experienced shortages of staff right across the trust, including Rampton hospital. Whilst a robust recruitment and retention plan was in place, the trust had over recruited by December 2015. However, it meant staff needed induction training and there was many new inexperienced staff on wards. The impact of the staff recruitment was not being felt on the wards. A ward manager stated that the time of inspection that no qualified staff could be rostered on shift for the following day. The clinical recruitment office was dealing with this shortfall.

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- Alford Ward was slightly over establishment with 26 whole time equivalent (WTE). The women's services had an establishment of 68.5 wte qualified nurses, with 2.3 wte vacancies. The women's services had over recruited support workers by 13.4 giving a total of 86.4 wte posts.
- There were 117 shifts covered by bank and 739 overtime shifts across Alford, Jade, Emerald, Topaz and Ruby ward between the 1 January 2016 to the 31 March 2016.
- Twelve-hour shift patterns were set. Core staffing levels on wards were set at seven staff on days and three staff on nights on most wards, Emerald ward had a core-staffing establishment of 13, however regularly operated with 11 on day shifts.
- Logs showed that staff left the ward to assist other wards during staff shortages, hospital data showed this occurred 224 times between 1 January 2016 and 31 March 2016. Staff maintained a log to monitor frequency and length of cover provided to other wards.
- Patients confirmed they had weekly one to one sessions with staff.
- On all of the wards, staff and patients told us that cancellation of activities occurred due to staff shortages. Cancellation of a horticulture group occurred during our visit. Records reviewed showed that rescheduling of healthcare appointments had also occurred due to staff shortages. We also noted that a patient had to return early from a trip to a prospective new placement, as escorting staff were required back at the hospital sooner than planned due to staffing. During our visit, one patient said that they were unable to have hair appointment 'due to staffing on the ward; another patient said they had had an occupational therapy session cancelled due to shortage of staff. A patient told us she previously received Occupational therapy (OT) input during her long-term segregation. However, she had not had this for five weeks. She did not know why and she described herself as lonely in her room as staff did not have time to talk to her, paint her nails, or write letters for her as they had in the past. Two patients reported to be "unable" to leave segregation due to ward commitments and staffing levels.
- Staff told us that sometimes closure of lounges occurred and patients confined to their rooms, to enable completion of administrative tasks. Sometimes zonal care occurred; this means patients stayed in one or two areas so that staff could monitor them. Staff did not keep records of when this occurred. This meant that patients were further restricted in their movements.
- The deployment of staff ensured critical tasks occurred, however, this left less time to directly engage with patients and undertake activities. For example, the nurse in charge undertook diary appointments, clinical administration, and electronic record administration. Another qualified nurse took charge of the clinic room and medications, leaving another qualified nurse to supervise observations, searches and stay mainly in the communal areas. Tasks allocated to unqualified staff included duties in the day and dining room, searches, observations, escorts, and provision of drinks.
- Most patients were on night-time confinement; this means locking patients in their bedrooms overnight. Staff reported that that staffing issues could affect the opening of bedroom doors on time in the morning. When this occurred, an incident report was completed and support requested. Trends in reporting show evidence that this time was a hot spot for. Incidents occurring.
- Alford ward had low sickness levels at 2.6% on the 1 April 2016. However sickness levels in the women's service were high. On the 1 April 2016 Emerald ward sickness levels were 21.2%, Jade 12.3% and 13.0% on Ruby. On the day of our visit, there were 11 staff members off sick on Emerald ward.
- Hospital data showed that between 1 April 2015 to 31 March 2016 Alford ward had a staff turn over of 9.6% and for the women's wards the turnover was 7.8%.
- Rotas showed that each ward had a responsible clinician and a ward doctor. The ward doctor was on the ward daily. Rotas showed that adequate out of hours medical cover was provided.
- All wards had achieved 100% mandatory training in breakaway and managing violence and aggression training, security, safeguarding adult and children, hand hygiene and promoting safer and therapeutic care.
- Training packages for risk and suicide awareness had been enhanced in November 2015. However the uptake of training was low. Observation training occurred within the mandatory three-yearly clinical risk training for clinical staff. On Alford ward out of 26 whole time

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equivalents since November 2015, two staff had received electronic risk learning, four face to face risk training and six electronic suicide awareness learning. In the women's service out of 156 whole time equivalents 14 staff had undertake electronic risk learning and 18 face to face risk training, 36 had undertaken electronic suicide awareness training and six face to face suicide awareness training. Trauma and self injury training figures were low for Emerald at 34%, Jade 58%, Ruby 43 % , Alford ward, staff do not have this training.

- We found that the trust policy 'treatment, risk assessment, and management of treatment risk training' was out of date (August 2014). The policy stated that training attendance was monitored and feedback given to managers. Monthly statistics were provided to the trust Board, the forensic services management board, the local services management group, directorate and service areas.

Assessing and managing risk to patients and staff

- During the period 1 January 2016 and March 2016 there were 31 episodes of seclusion relating to 16 patients. In the same period 46 episodes of long term seclusion occurred effecting 45 patients.
- Senior managers received a daily written report; this consisted of who was in seclusion and long-term segregation. It provided very little information to make managerial decisions upon. The report did not detail staffing or incidents that occurred within that 24 hour period.
- One patient expressed concern about the number of patients in segregation in the hospital, which together with night-time confinement led to patients being isolated for long periods, and stated that it did not contribute to good mental health. Another patient told us night-time confinement was their worst time, resulting in self-harm.
- The hospital did not have a separate suicide prevention policy; staff informed us that suicide prevention threads ran through into other trust policies such as risk assessment and management. The hospital did have a suicide and self harm awareness training package for staff, this stressed the importance of carrying out observations..
- Not all staff had signed that they had read the policies and procedures on the form attached to each policy; this meant that it was not clear if staff had read and understood policies.
- A policy for the use of mechanical restraint for review in 2017 was in place. Mechanical restraint usage occurred in exceptional circumstances to prevent self-harm based on risk assessments. We saw entries in the daily planner/handover book that patients were on constant observations and loosening of restraints occurred as the patient's condition improved.
- Staff on two wards gave us an observation policy dated January 2015. On Ruby ward six out of 34 staff had signed, they had read it in March 2016 and on Emerald ward only two staff had signed. The trust subsequently gave us an observation policy with an implementation date of February 2016. This meant that ward staff had not read the up to date policy that they were working to. Managers could not track staff reading an electronic version of a policy to update their knowledge. Therefore, there was an overall lack of assurance about staff understanding.
- The hospital introduced a daily planner and handover template in October 2013 in the form of a book to ensure that all wards were using the same document for logging staff activity, daily planning activity, security information and patient activity. We found that there was inconsistent completion of this book.
- The trust policy stated that the nurse in charge of the ward was responsible for nominating staff to undertake observations and the allocation of staff should be recorded in the daily planner. The daily planner was not completed to this effect. Staff on Emerald ward recorded the allocation of constant observation on a piece of scrap paper daily. Two staff members on Emerald ward confirmed that arrangements for undertaking general 15 minute observations and five minute observations were 'ad hoc'. No one person was allocated to do observations. Staff knew that observations needed to be done and each side of the ward took responsibility for carrying out observations collectively.
- The trust policy stated that the person undertaking the observation should sign they had done so. There were gaps in signatures for observations. For example on Jade ward, on the 17/3/16 to 18/3/16 there were no signatures. On Ruby ward, there were gaps in signatures

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on the 17/3/16 and on the 10/4/16 for one patient's constant observations. On Emerald ward, there were gaps in signatures on the 18/4/16; it was therefore unclear who had carried out the observations. One member of staff confirmed that observations were ticked on Emerald ward on the 5 February 2016, however, had not signed as they had relied on another staff member completing it. This means that it is unclear who carried out the observation and places patients at risk if the observation is unaccounted for.

- The trust policy stated, "The exact times should be specified in the patients' healthcare record and in the subsequent observation plan". Two spiral bound books were used to record observations for night shifts and another for day shifts on the four wards visited. Emerald ward used forms that had pre-printed times for general observations and for five-minute observations. All wards recorded observations on the quarter of an hour (i.e. 9.00, 9.15, 9.30, 9.45). As patients were in different parts of the ward it would not be possible for one staff member to observe and record at precisely on the quarter of the hour, therefore the actual time of the observation was not being recorded.
- All patients were aware that they were on 15-minute observations. One patient said however that their observations were not done every 15 minutes. We were concerned that patient's intent on self-harm could do so by timing the observation interval if it was predictable.
- The trust policy required 30 minute general observations to account for patient's whereabouts. In the women's service, it was custom and practice to undertake them every 15 minutes due to the higher level of risk and self-harm. The hospital policy however did not reflect this practice.
- The trust policy stated that the observation plan for constant, intermittent, within eyesight, or within arm's length observation should be reviewed by the responsible clinician/delegated multidisciplinary team (MTD) member every 24 hours. Two staff said that this did not occur and four sets of records reviewed did not demonstrate the recording of discussions about observations by the multidisciplinary team.
- Staff informed us that general observations were reviewed in the weekly multi-disciplinary team (MTD) meeting; however, patients may not be present. Patients told us the MDT saw them for a discussion four weekly. Four records reviewed did not demonstrate the recording of discussions about general observations by the MTD.
- In 2015 the hospital carried out an audit of the observation of patient procedures. It found that 75% patients on increased observations had an observation plan in the patient record, and 8% patients had nursing care plans that were specific to observations. All patients had their level of observations stated either on their observation plan/care plan or electronic patient record. There was relatively poor documentation to indicate that the levels of observation had been reviewed by the responsible clinician/MDT in line with the requirements of the procedure, however it did appear that where these were reviewed. Although the use of observation plans was evident these were not always utilised to their full potential as some of the information was missing. The filing system for completed paperwork was not standardised and it was also found that the correct standardised paperwork for patients on enhanced observations within the women's service was not being used.
- We saw CCTV footage for the 5 February 2016 for Emerald ward. The footage shows that four checks occurred outside of the 15-minute observational interval and delays of 5 – 20 minutes occurred.
- On Alford ward, CCTV footage of the 17 March 2016 showed that;-
 - ten checks were outside the 30 minute policy guide
 - one patient on observation had an interval of 55 minutes between checks.
 - one patient was missed on two separate checks.
 - one patient was not checked for over 90 minutes.This means patient safety would be potentially compromised where risks had been identified.
- CCTV footage on 17 March 2016 on Emerald ward showed a member of staff sat outside a patient bedroom with the door closed. The member of staff remained seated without being able to look in through the door panel and the roaming member of staff on observations did not always carry out observation, appearing to rely on the seated member of staff.

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- CCTV footage on Ruby ward showed a staff member on a 2:1 observation sat with their eyes closed for 20 minutes. We were concerned that observations could not occur in this situation.
- On Alford and Emerald wards, the linen room door was open occluding the view of a camera which prevented a clear image of staff that were sat for long periods. Staff moved a chair from seclusion room and located this outside the staff office with the chair back to a camera. Staff used a chair to raise their feet while sitting in the chair. Staff used blankets and pillows. We were concerned that observations were compromised in this situation.
- The hospital did not undertake regular audits of CCTV footage to monitor implementation of the observation policy. Staff were unaware of the 2015 audit results on the implementation of the observation policy.

Track record on safety

- The hospital monitored trends for suicide and self-harm. Between 1988 and 2015 fifteen suicides occurred. Between January and December 2014 out of 32 suicide attempts 24 occurred the women's services. The highest trends in self-harming occurred in the women's service. In the period, 2014/2015 there had been 674 attempts of self-harm in the women's service, this meant that they required higher observation levels. Wards received trends analysis reports about the type of self-harm
 - There were four serious incidents between 1 April 2015 to 31 March 2016. We reviewed four serious incidents. Some of these were currently under investigation by the trust and coroner. The trust had appointed an external investigator from another high security hospital to investigate one recent serious incident.
 - During the period 1 April 2015 to 31 March 2016 the hospital had exercised a duty of candour on four occasions (this is when something has gone wrong and the patient and relative are informed). We noted for example a medication error had occurred in June 2015 and staff had apologised and informed the patient. Staff reported the incident stating the ward had been "locked down" because there were only four staff.
- There was a five-day delay in reporting a death to the CQC; regulation 16 of the Health & Social Care Act 2008 requires providers to notify CQC without delay.

Reporting incidents and learning from when things go wrong

- Staff understood how to report incidents.
- There were 1550 incidents reported by staff between 1 April 2015 and 1 April 2016 on the four wards visited. The hospital analysed the incidents by type and frequency and the information was provided to wards
- Evidence or learning and changes in practice following incidents was difficult to gauge. Staff told us that the only immediate change in practice following a serious incident led to the introduction of spiral bound observation form booklets. One for day observations and another for night time confinement. Lessons learnt following a serious incident several months prior to our inspection remained to be identified because the detailed investigation had not been concluded. In one cross team investigation report, recommendations had been made; however, no action plan was attached. Therefore, it was not clear by which dates change should occur by and who would assume responsibility for identified actions. One of the recommendations was to provide training to staff on observations. Emerald ward staff we spoke with confirmed they had not received such training. Training figures showed that only three staff had undertaken an electronic risk learning module, and three had received face to face risk training, 15 had undertaken an electronic suicide awareness learning module. This means not all staff had completed the training.
- Records did not show that opportunities to review and update risk assessments when patients were expressing strong desires to self-harm were completed.
- Staff noted there had been an increase in self-harming and suicidal behaviour amongst the Emerald ward patients following a death. Consequently, restrictions on access to belongings and items occurred more than previously.
- Patients and staff confirmed they received debriefings together through senior managers following a serious incident. Chaplain and psychology staff provided support to patients. Remembrance service occurred in the event of a patient death.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- Although all 18 of the records that we viewed had several care plans in place; the care plans did not demonstrate patient involvement or views. Care plans were comprehensive and up to date.
- Records viewed showed good physical health monitoring and patients had annual physical healthcare checks. We found evidence of staff working proactively to support six patients in managing their diabetes.
- The hospital made use of paper and electronic patient records which were stored securely.

Best practice in treatment and care

- The trust observation policy was based on the national institute of health and care excellence
- Team leaders carried out audits of care plans, physical health, treatment risk information management systems, ward rounds and single healthcare records, care programme approach and restrictive practice. The form used also audited if patients had received a minimum of four named nurse sessions in a month. The named nurse received the audit results and improvements identified. Team leaders monitored improvements made during clinical supervision sessions.

Skilled staff to deliver care

- The multi disciplinary team consisted of consultants, doctors, nurses, occupational therapists, social workers and psychologists.
- New staff received a three day induction, a ward induction, and an information pack on commencing employment. A six week preceptorship programme was in place so that staff could orientate and be given support in providing care to patients.
- Staff had access to specialist training such as sensory integration training to provide care to patients with autism, dialectical behavioural therapy and the violent offender treatment programme. Nursing assistants accessed a care certificate rolling programme.
- The number of staff provided with personality disorder training was low. The trust provided data that between

2011 – 2013 there were a total of 79 staff from the women's service that attended the knowledge and understanding framework training for personality disorder.

- Between 1 April 2015 to 31 March 2016 the level of clinical supervision fell on Alford ward to between 45% to 57%, managerial supervision was higher at 76% for ten months during the year. The level of supervision was good on the women's service was good ranging between 80-93 %. Staff on the women's wards confirmed they received individual managerial and clinical supervision and had access to weekly group supervision.

Multi-disciplinary and inter-agency team work

- Patients and staff reported good multidisciplinary working. Review of each patient's treatment and records occurred weekly and the responsible clinician saw patients every month.
- The hospital employed registered adult nurses to provide advice and support for physical healthcare on the wards.
- The hospital had a daily planner and handover book, however it was not used to maximum effect. The aim being to allocate tasks, have an overview of the staffing and provide a structured handover between shifts. These varied greatly in detail. For example, handover information varied from nothing recorded for patients to short statements of 'settled' to full description of daily activity and mental state. The daily planner book had a section to record staff breaks taken. This was not recorded on one ward and inconsistently in other wards. Only one out of 13 daily planner records reviewed recorded that fresh air access and perimeter checks completed. Other wards recorded it inconsistently.
- There was good inter-agency working with commissioners to identify suitable placements to step down from the high secure setting.

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

- Detention papers were reviewed and appeared to be in order, filed correctly and were up to date.
- Notes reviewed showed appropriate recording of assessment of capacity and discussion around consent for medication.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- We found authorised treatment certificates attached to medication charts, so that staff understood the legal authority under which they administered medication.
- Authorised medication treatment certificates for non-consenting patients were several years old. Three were dated 2010 and one 2009. Reviews took place through the Section 61 forms sent to the CQC.
- An independent mental health advocate (IMHA) attended the ward and community meetings to support patients in exercising their rights.
- Records showed that patients had received information about their rights, including IMHA. Staff had repeated the information at intervals.
- Patients told us they understood their right to appeal against their detention to a mental health tribunal. Some had experience of the tribunal. Staff referred patients to a tribunal who had not exercised their rights to appeal for some time.
- Section 17 leave had been authorised on standardised forms, which included risk assessments. Leave was authorised by the security department in conjunction with the multidisciplinary team and the responsible clinician. Patients had Section 17 Leave documented for emergency escort to hospital for physical emergencies.
- Staff undertook Mental Health Act training as part of their mandatory training.
- The Mental Health Act administration monitored the MHA and provided advice to staff.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- The majority of patients on the wards stated that they felt safe and staff were respectful and caring.
- Staff understood the needs of patients and were dedicated in their roles and caring towards the patient group.
- We observed some positive interaction between patient's and staff. The majority of patients were enthusiastic about their care and treatment on the ward.

The involvement of people in the care that they receive

- Two patients we spoke to said they had their care plans discussed with them.
- Three patients' confirmed that advocacy visited the ward and they could speak to them if they wished.
- Patients had received a distress signature book. The purpose was to record how they wished to be treated should they become distressed. The booklet supported patients in recognising their strengths and the goals they wished to achieve. Patients kept the booklet in their room. It was unclear how the information linked to the care plan.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- NHS England commissioned placements at the hospital. The target occupancy the hospital aimed for was 93%. The overall occupancy rate between 1 April 2015 and 31 March 2016 was between 90 to 98%.
- Records reviewed showed that staff had been proactive in arranging assessments and negotiating with commissioners in order to enable patients to move to less secure placements. However, there were four patients who had been waiting over a year for a transfer to a less secure setting. Discussions were taking place with commissioners to find beds.

The facilities promote recovery, comfort, dignity and confidentiality

- We saw a notice board providing information about the ward routine to assist patients.
- The hospital was commissioned to offer a minimum of 25 hours of activity. Patients had their own individual activity programmes set.
- The ward activity programmed scheduled daily walking groups for fresh air. It was mandatory for all patients on the ward to attend at least three times a week. Sections

identifying if fresh air had occurred in the daily planner book were blank so it was not clear if they had happened. Patients told us that some structured programmes such as sewing groups had reduced from twice a week to once a week at the education centre. One patient had found a visit to the library cancelled. Staff and patients expressed concern that lack of staffing hindered activities on the ward.

- One patient told us that they had to ask permission to go into the ward garden; access depended on whether there was enough staff to escort them.
- There was an education centre providing a range of activities for patients such as coffee mornings, choir, and talking therapies.
- The hospital audited the uptake of activities. Ruby and Jade ward on average offered less than 25 hours of activity per week. Emerald and Alford ward offered more than 25 hours per week on average. Each patient did not take up all activities offered, averaging between 43% to 57% take up of activity in total. Between two and five hours of fresh air was offered to patients on average, the take up was low between 15 minutes and 29 minutes.
- Patients had their own keys for lockers and bedrooms based on risk assessments.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Leadership, morale and staff engagement

- Staff reported access to counselling, and clinical supervision in groups or one to one following serious incidents.
- All staff on shift at the time of a serious incident had a debriefing. Cancellation of a team away day occurred following a serious incident, and rescheduled several weeks later. The staff felt this was not supportive for the team.
- All new staff received six-week preceptorship support when commencing employment.
- On the 1 April 2016, the hospital management committee approved the implementation of an immediate observation action plan. This was in order to review the observational policy, increase staff understanding of safe practice in carrying out observations and to audit safe practice through CCTV footage review. It was too soon to evaluate the impact of the action plan.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

The regulation was not being met because;

- Not all staff had signed that they had read the observation policy.
- Closed circuit television footage was not audited to check the observation policy was implemented.

We found instances of ;

- observations being carried out late
- staff signature gaps in the observation records reviewed
- pre-printed times on observation forms were used; therefore, observations were not recorded at the time they were done
- records reviewed did not show the responsible clinician had reviewed frequent observations daily

This section is primarily information for the provider

Enforcement actions

- Staff had not received further training following recommendations from serious incidents.
- CCTV footage showed some observations had been undertaken late.