Arbury Court

Quality Report

Townfield Lane, Winwick, Warrington, WA2 8TR
Tel: 01925 400 600
Website: www.elysiumhealthcare.co.uk

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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	Good
Are services safe?	Requires improvement
Are services effective?	Good
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 **good** because:

- Ward environments, including clinic and seclusion rooms, were safe and clean. Almost all staff were compliant with mandatory training. Individual risk assessments were up to date and included all relevant information. Staff followed the principles of least restrictive practice and used de-escalation and positive behaviour support to manage conflict where possible. Safeguarding procedures were effective and medication was stored and administered correctly. Serious incidents were investigated, and lessons learned were shared with staff.
- Patient care plans were up to date, holistic and recovery-focused. Care plans were informed by detailed assessments. Patients had their physical healthcare needs assessed and treated where necessary. Patients had access to evidence-based psychological and occupational therapies that were appropriate to their individual needs. Most staff were up to date with clinical supervision and appraisal. Practice was compliant with the Mental Health Act and Mental Capacity Act.
- Patients and carers were mostly positive about the staff and the service. Patients described staff as supportive, friendly, respectful and caring. Patients were involved in their own care, in staff recruitment and training, and in making decisions about the running of the hospital. Patients and carers said that the service responded to their complaints and concerns.
- New referrals were assessed and admitted quickly. Arbury Court staff worked closely with commissioners and patients to plan discharge. There were rooms and facilities available for a wide range of patient activities, as well as a recovery college and a real work programme. Individual needs (including mobility, learning disability and cultural needs) were catered for. The service effectively responded to complaints.
- The provider's vision and values were reflected in staff behaviour and attitudes. There was an effective clinical governance structure in place. Electronic 'dashboards' were used to monitor and improve the care of individual patients and the overall performance of the wards and hospital. Managers had responded to staff concerns about patient aggression and incidents, for example by employing a psychotherapist to support staff. Staff told us that they felt supported and able to raise concerns. Arbury Court had a very low sickness rate.

However

- A number of patients had missed doses of physical health medication due to a lack of stock. Staff did not always fully monitor and record a patient's physical health during clozapine initiation and after rapid tranquilisation.
- Staff and patients told us that wards were busy and that there were not always enough staff to meet needs.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Good

Arbury Court

Services we looked at:
Forensic inpatient/secure wards; Acute wards for adults of working age and psychiatric intensive care units.

Summary of this inspection

Background to Arbury Court

Arbury Court has 82 beds for women aged over 18 diagnosed with a mental illness or personality disorder. Some of the women may have a learning disability in addition to a mental illness. All patients are detained under the Mental Health Act. Five of the wards provide forensic or secure services, and one ward is a psychiatric intensive care unit.

There are 44 low secure beds across three wards:

- Appleton ward - 15 beds
- Cinnamon ward - 14 beds
- Heathfield ward - 15 beds.

There are 27 medium secure beds across two wards:

- Delamere ward -12 beds
- Oakmere ward - 15 beds.

There are 11 psychiatric intensive care beds on Primrose ward. Primrose ward has its own consultant psychiatrist, ward manager and nursing team, but is integrated within the rest of the service.

Patients are admitted from across the United Kingdom. Secure beds in England are commissioned by NHS England, and different authorities in Wales and Northern Ireland. Beds in the psychiatric intensive care unit are commissioned by individual NHS trusts and authorities.

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.

Arbury Court did not have a registered manager at the time of our inspection, as the application was in progress. This has been completed, and a registered manager was approved shortly after our inspection.

Arbury Court was previously registered with the Care Quality Commission under a different provider. Elysium Healthcare registered Arbury Court on the 21 October 2016. This is its first inspection under this registration.

Our inspection team

The team that inspected the service comprised an inspection manager, three inspectors, a specialist pharmacy inspector, two Mental Health Act reviewers, an inspection planner, an expert by experience, a consultant psychiatrist, three nurses, and an occupational therapist.

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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and spoke with patients across all six wards at Arbury Court.

During the inspection visit, the inspection team:

- visited all six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 31 patients, including those we spoke with the week before the inspection
- spoke with the hospital director, and managers or acting managers for each of the wards
- spoke with over 26 other staff members including doctors, nurses and healthcare support workers, occupational therapist, psychologists, social workers and support staff
- spoke with four carers or family members of patients
- attended and observed three multi-disciplinary or care programme approach meetings, two hand-over meetings, a community meeting, and occupational therapy or activity groups
- collected feedback from 10 patients using comment cards
- looked at 33 care and treatment records of patients
- carried out a specific check of the medication management on all six wards
- carried out a specific check of the use of seclusion and long term segregation
- looked at a range of policies, procedures and other documents relating to the running of the service.

We have reported on forensic/inpatient secure wards and the psychiatric intensive care unit together within this report due to the relatively low number of beds within the psychiatric intensive care unit.

What people who use the service say

We spoke with 31 patients, four carers or family members of patients, and received 10 comment cards. Patients and carers were mostly positive about the staff and the service. Patients told us that their relationships with staff were supportive, friendly and relaxed. They found the practice nurse and the GP helpful in meeting their physical health care needs. Many patients told us that they found the activities beneficial, were involved in their care and felt safe in the hospital. Carers said that the service had responded when they had raised concerns or complaints.

However, some patients said that the wards were busy, that there were not always enough staff and that this meant they did not always feel safe. Some patients found the activities boring and some were unhappy about restricted access to bedrooms during the day. Some patients told us that the quality and choice of food was limited, and some said that they were not always involved in their care.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- A number of patients had missed doses of physical health medication due to a lack of stock.
- Staff did not always fully monitor and record a patient's physical health during clozapine initiation and after rapid tranquilisation.
- Arbury Court's rapid tranquilisation policy did not reflect current best practice guidance, and staff were incorrectly rapid tranquilisation.
- Arbury Court had a high number of vacancies for registered nurses and staff told us that maintaining adequate staffing levels could be challenging
- Medical and multi-disciplinary team reviews for patients in seclusion and long-term segregation were not always easy to find in records.

However:

- Wards were clean, furniture was well-maintained and seclusion rooms met the requirements of the Mental Health Act Code of Practice.
- Clinic rooms contained all necessary equipment, and emergency equipment was checked regularly.
- Arbury Court had put strategies in place to ensure safe staffing levels despite the number of vacancies for registered nurses.
- Almost all staff were up to date with mandatory training.
- Individual patient risk assessments were up to date and included all relevant information.
- Staff followed the principles of least restrictive practice, and balanced positive risk-taking with the need to keep patients safe.
- Staff used de-escalation and positive behaviour support to manage conflict situations, meaning that restraint was only used as a last resort. A 'reducing restrictive practice' meeting was held once a month.
- There were effective safeguarding procedures in place, and staff knew how to identify and respond to potential safeguarding concerns.

Senior staff investigated serious incidents and implemented recommendations to reduce the likelihood of recurrence.

Are services effective?

Good

We rated effective as **good** because:

Summary of this inspection

- Patients had detailed assessments carried out after admission, which informed care plans. Care plans were up to date, holistic and recovery focused.
- Patients had their physical healthcare needs assessed and treated where necessary.
- Patients had access to evidence-based psychological and occupational therapies that were appropriate to their individual needs.
- Eligible patients with a learning disability had regular care and treatment reviews.
- Arbury Court used recognised rating scales to monitor health and outcomes for patients.
- Elysium Healthcare had an organisation-wide audit cycle, which included auditing prescription of high-dose antipsychotics.
- Most staff were up to date with clinical supervision and appraisal.
- Multidisciplinary meetings were effective and respectful of patients' views.
- Mental Health Act documentation was mostly in order. Patients had their rights explained to them regularly.
- An independent Mental Health Act advocate was based within the hospital.
- Staff had a good understanding of how the principles of the Mental Capacity Act applied to patients, and care records included best interest discussions where appropriate.

However:

- Medicines prescribed on prescription charts were not always included on the Mental Health Act consent to treatment form.

Are services caring?

Good

We rated caring as **good** because:

- Arbury Court held regular 'patient council' meetings, attended by patient representatives and by staff who could make decisions and changes within the hospital. All issues raised were taken seriously and acted upon.
- Patient representatives attended clinical governance meetings and meetings to review commissioning for quality and innovation national goals.
- Patients were involved in staff recruitment and training.
- Patients were involved in their care and planned their own care programme approach meetings.
- Patients and carers were mostly positive about the staff and Arbury Court.

Summary of this inspection

- Patients described staff as supportive, friendly, respectful and caring.
- Carers had the opportunity to attend a carers' group.
- Patients and carers knew how to complain and said that Arbury Court responded to their concerns.

Are services responsive?

Good

We rated responsive as **good** because:

- Arbury Court assessed new referrals quickly, and there was no waiting list for a bed.
- Arbury Court was actively involved in identifying more suitable placements for those few patients who were not progressing at Arbury Court.
- Patients on the forensic wards formally discussed discharge plans at care programme approach meetings every six months.
- There were rooms and facilities available for a wide range of activities, including hairdressing and beauty, a gym and a shop. There was also a multi-faith room.
- Activities were available seven days a week, and patients' access and attendance were monitored through the hospital's dashboard.
- Arbury Court had a recovery college and a real work programme.
- Arbury Court had adapted to meet patients' specific needs.
- Information was provided to patients in an accessible format.

Arbury Court effectively responded to patient and carer complaints.

Are services well-led?

Outstanding

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

- The leadership, governance and culture were used to drive and improve the delivery of person-centred care. Governance and performance management arrangements were proactively reviewed and used to influence and improve care.
- Arbury Court had an effective clinical governance system. This included an electronic 'dashboard' that was used to monitor the care of patients, and was used to improve care for individual patients. This was accessible by senior managers, clinicians and ward managers, who used the information on a daily basis. The dashboard was also used to look for themes and areas for improvement across the hospital, and to provide information for commissioners.

Summary of this inspection

- Patients were an integral part of the development and governance of the hospital. There was an active patients' council, and patient representatives attended governance and development meetings.
- Managers were responsive and innovative to challenges within the service. This included extending the availability of senior staff out of hours, and employing a psychotherapist to provide support for staff. A unit wide tidy up was turned into a 'clutterbug' event, to positively engage patients and staff in the process.
- Staff and patients were positive about their managers, and overall morale was good, whilst acknowledging that the wards could be very busy. Staff told us that they felt supported by colleagues, managers and senior managers, and that they felt able to raise concerns. Arbury Court had a low staff sickness rate (1.7%).

Detailed findings from this inspection

Mental Health Act responsibilities

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

We did not carry out a Mental Health Act review of the service. However, we reviewed Mental Health Act documentation and consent to treatment forms as part of our general records and medication checks. All patients at Arbury Court were detained under the Mental Health Act.

Patients had their rights under the Mental Health Act explained to them regularly. Patients had access to an independent Mental Health Act advocate who was based at Arbury Court.

Most of the Mental Health Act documentation we reviewed was completed correctly. However, we found that of 57 prescription charts we looked at, 13 contained medication that was not included on the necessary Mental Health Act form.

A Mental Health Act administration team oversaw the implementation of the Mental Health Act, which included scrutinising documents, and requesting amendments if errors were found.

Ninety percent of staff had completed training on the Mental Health Act and Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

All patients at Arbury Court were detained under the Mental Health Act. There had been no Deprivation of Liberty Safeguards applications.

Staff had a good understanding of the principles of the Mental Capacity Act, and how these applied to the patients at Arbury Court.

Care records included an assessment of each patient's capacity, which was usually in relation to a specific treatment such as medication. We saw positive examples of best interest discussions when patients lacked capacity to make decisions about surgery or medication for physical health conditions.

Patients had access to an independent Mental Capacity Act advocate when required.

Ninety percent of staff had completed training on the Mental Capacity Act and Code of Practice.

Overview of ratings

Our ratings for this location are:

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

Good

Forensic inpatient/secure wards

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

Are forensic inpatient/secure wards safe?

Requires improvement

Safe and clean environment

Environmental risk assessments, which included ligature audits, were carried out annually on all the wards. These were last carried out in March and April 2017. There were no outstanding actions from the ligature audits, and risks were managed or mitigated. Risks had been removed or reduced in the hospital by using antiligature fittings in bedrooms and bathrooms, locking of high risk areas such as bathrooms and kitchens, and using mirrors and closed circuit television in less observable areas.

The hospital had a security and safety booklet that provided clear information for staff. This included access and security of the buildings, emergency alarms, high risk and prohibited items, patients' leave and enhanced observations, infection control, and emergencies. There were leads for health and safety and patient safety and security. The hospital had a comprehensive health and safety audit programme, which was up to date and included environmental risks, ligatures and fire safety. All ward managers and charge nurses were trained as fire marshals. Security briefings were circulated to staff, and shared learning about potential health and safety or security issues.

There were airlocks into each of the clinical buildings on site, and staff electronically accessed keys before going into the building. The doors between the psychiatric intensive care unit and the adjoining forensic ward were locked. This was accessible in the event of an emergency, but was alarmed to prevent it being used routinely as a thoroughfare. There were nurse call points in patients' bedrooms, and all staff carried alarms. We observed that staff responded promptly when the alarms were activated. A health care worker was assigned the role of security nurse on each of the wards each shift. Their responsibilities included carrying out environmental checks throughout the shift, and monitoring patients, staff and visitors entering and leaving the ward.

Staff were aware of security issues around the building, and knew how to access policies about security. Staff received security training every year, and were familiar with security protocols. There were posters around the site and staff were familiar with 'See Think Act'. This was an initiative promoted by the Department of Health and the Royal College of Psychiatrists about relational security.

An external company carried out a fire audit of Arbury Court. There was cladding on the training building, but this was not found to be a high risk. Fire drills were carried out, which were mostly satisfactory. When issues were identified, such as staff bringing out drinks, this was addressed.

The wards were clean, and furniture was maintained. Housekeeping staff were directly employed by the hospital, and there was an allocated housekeeper on each ward. They had cleaning checklists, and linked in with nursing staff. They had locked boxes when they took cleaning materials and equipment onto the wards. Following an incident, housekeepers controlled the number of bin and laundry bags on the wards. The hospital had its own team of maintenance and garden staff. Patient environment assessment team audits took place of the whole unit

between the 25 April and the 2 May 2017. These identified some low risk actions to be carried out on each ward, such as high level dusting, and a deep clean of one of the ward kitchens. All the actions identified had been completed.

There were seven seclusion rooms across the hospital, which included a seclusion room on the psychiatric intensive care unit (Primrose ward). The rooms were in keeping with the Mental Health Act Code of Practice. This included externally controlled lighting and ventilation, a clock, access to toilet and shower facilities, and an intercom to speak with staff. Some of the wards had closed circuit television so that staff could observe patients in the toilet/shower area from outside the room. Staff told us that this would only be observed by a female member of staff, and was a live feed that was not recorded. Safe bedding and strong clothing was available for patients, if there was a risk of self-harm from normal fabrics. Bedrooms had been adapted for patients in long term seclusion and segregation.

The clinic rooms on the wards were clean and well maintained. They contained resuscitation equipment, oxygen, automatic external defibrillators, and emergency medication to be used in the event of a medical emergency. Physical examinations were usually carried out in a separate clinic room elsewere in the hospital building. Staff carried out routine checks of emergency equipment.

Eighty-three per cent of 224 eligible staff had completed infection control training. Ninety-eight per cent of 50 eligible staff had completed infection control training for working in non-clinical areas. The service's most recent food hygiene inspection was carried out by the local council on the 18 May 2017. It received the top rating for hygiene. Ninety-one per cent of eligible staff had completed food hygiene training.

Safe staffing

The service had registered nurse vacancies, but there were active plans to address these. There were 68 registered nurse posts or whole time equivalents, from which there were 22.1 vacancies. Interviews had taken place, and posts had been offered to 17 nurses. The service had 109.5 healthcare worker posts, which was 20 staff over the services allocation. The service recruited above its allocated staff level to cover the additional staff required to cover enhanced observations and leave. There were 1.8 vacancies healthcare workers, and the service held regular open days to recruit new staff.

The service used the safer staffing model used in the NHS to monitor its staffing levels. Each of the forensic wards had a base staffing level, and this was adjusted depending on the needs of patients. The psychiatric intensive care unit did not have a fixed core staffing level, as every patient had different needs so staffing levels were adjusted on a daily basis. Managers discussed staffing at a daily morning meeting. This took account of the acuity or business of the wards, the number and experience of staff across the site, the staff required on each ward to cover the shift and carry out observations/seclusion, planned activities and leave. Staff were moved between wards if necessary to ensure that there were enough experienced and familiar staff across all the wards. Managers also covered shifts if necessary. Managers and human resources staff held weekly and monthly meetings to look at staffing levels for the coming week, and use of bank and agency, and ongoing recruitment needs and plans.

Patients and staff told us that the wards were very busy. Staff told us that maintaining adequate staffing levels was challenging, but there were usually enough staff to provide the service. Bank nurses and healthcare workers, and agency healthcare workers were regularly used, and these were staff familiar with the service as far as possible. Staff told us that activities were rarely cancelled because there were not enough staff to provide them, but that leave may occasionally be postponed. Managers told us they were able to bring in extra staff when required.

The service regularly used enhanced observations, where patients have a member of staff with them at all times. If there was one patient on enhanced observations then this would be covered from within the core nursing levels on the ward, but for additional observations extra staff would booked. Additional staff could be provided to cover acuity of the ward, leave, and planned activities or appointments.

In the six month period up to 30 June 2017, 738 shifts had been filled by bank staff (29 of these were on the psychiatric intensive care unit), and 633 shifts were filled by agency staff (107 of these were on the psychiatric intensive care unit). Sixty shifts remained unfilled. The service had a contract with one nursing agency to promote continuity in the supply of agency healthcare workers. Agency registered

nurses were not used. All agency staff received an induction, and were trained in breakaway techniques as a minimum requirements. Agency staff had either not completed management of violence and aggression training, or the training they had received was different to the type used at Arbury Court. The service had identified this as a potential problem, as agency staff may respond or intervene differently to permanent staff. Managers told us this had been discussed with the nursing agency, and there were plans to train some of the agency staff who worked regularly at Arbury Court in the same techniques as its permanent staff.

The service had 5.2 whole time equivalent consultant psychiatrists, who were all in post. This included the medical director, responsible clinicians for all 82 patients at Arbury Court, and medical cover for a sister hospital with 21 beds. The psychiatric intensive care unit had 0.7 whole time equivalent of a consultant psychiatrist. Physical healthcare was provided by a GP who attended routinely, and the practice nurse. Doctors told us that their workload was increased by high levels of Mental Health Act reports and reviews of patients in seclusion.

Doctors provided out of hours medical cover across four Elysium hospitals in the North West, with a separate on call rota for the psychiatric intensive care unit. Doctors were required to work one day in seven. They told us the main duties were seclusion and long term segregation reviews, and this could be challenging if there were several patients in seclusion at each of the hospitals, which were across a large geographical area. The doctors were available for potentially serious incidents or urgent reviews. Admissions to the forensic service were planned and usually happened in the working day, but urgent admissions to the psychiatric intensive care unit may need to be assessed out of hours. Staff told us that on call medical cover was available when required, which included reviewing patients who had been secluded.

Most staff were up to date with their mandatory training. Ninety-eight per cent of staff had completed management of violence and aggression training, 89% had completed safeguarding training, 91% health and safety training, and 90% responding to medical emergencies training. Almost all staff (253 out of 256) had completed conflict resolution training. Infection control training had the lowest compliance rate at 83% of staff. The service had a lead for training who developed the mandatory training schedule, co-ordinated training, and provided some of the courses. There was a practice development team who provided training and support in clinical skills for nursing staff. Training was online and at various Elysium sites, which included a dedicated training centre at Arbury Court. There was a training matrix, which showed the mandatory training required for individual job roles.

Recruitment checks were carried out for all staff before they started work at the service.

Assessing and managing risk to patients and staff

We reviewed 33 care records. All patients had an up to date risk assessment. On the forensic wards these were carried out using research-based tools such as the Short-TermAssessmentofRiskand Treatability, and the Historical, Clinical, Risk Management-20. Risk was routinely discussed and reviewed at the daily hospital-wide management meetings, and in multidisciplinary team meetings. Care plans or positive behaviour support plans were updated as a result of this.

The service monitored the use of restraint, which included prone restraint, and gathered detailed information about each incident. In the six months up to 4 July 2017 there had been 874 incidents of restraint, involving 75 service users. The lowest number of restraints was 26 on Heathfield ward (low secure rehabilitation ward), and the highest was 356 on Delamere ward (medium secure admission ward). On the forensic wards there had been had been 83 incidents of prone restraint, 45 of which resulted in rapid tranquilisation. Primrose ward, the psychiatric intensive care unit, had 161 restraints involving 25 patients. Thirteen of these incidents involved prone restraint, nine of which resulted in rapid tranquilisation.

Each patient had a positive behaviour support plan which included a patient's views and wishes. The plan aimed to de-escalate a situation so that a patient's distress did not reach the point where restraint was considered necessary. Patients told us that after they had been restrained, a member of staff would usually come and talk with them about it afterwards.

Ninety-eight per cent of eligible staff (178 out of 182) had completed management of violence and aggression training. Almost 100% of staff (254 out of 255) had completed breakaway training. Training in the use of physical or hands-on restraint incorporated the use of

restraining patients on the floor as a last resort, and if this did occur it should not intentionally place patients in a prone position. If this did occur, the training included how to turn a patient into the face-up position.

In the six month period up to 4 July 2017 there were 148 episodes of seclusion, and 19 incidents of long term segregation. There had been no incidents of seclusion or long term segregation on Heathfield ward. Cinnamon ward had eight incidents of seclusion and no incidents of long term segregation. Appleton ward had 29 incidents of seclusion and nine of long term segregation. Oakmere ward had 34 incidents of seclusion and one of long term segregation. Delamere ward had the highest number of incidents of seclusion at 48, with four incidents of long term segregation. Primrose ward, the psychiatric intensive care unit, had 29 incidents of seclusion and five of long term segregation.

At the time of our inspection there were seven patients in seclusion and six patients in long term segregation. We spoke with nine patients in seclusion or long term segregation, checked 10 records, attended a seclusion review, and looked at the seclusion room environments on Delamere, Appleton and Oakmere wards. The environments where patients were secluded were satisfactory, patients were involved in discussed about seclusion and long term segregation, and interactions with staff were positive. Attempts were made to improve interactions and daily life for patient in longer term segregation or seclusion. For example, adaptations were made to the environment, activities were promoted, and calls and visits from family members were facilitated. Even in the context of seclusion, least restrictive options were considered. For example, whether patients were able to wear their own clothing as opposed to 'strong' clothing (that cannot be torn to create a ligature). Seclusion documentation was generally completed satisfactorily, to ensure that the necessary checks and safeguards were carried out. Medical reviews were carried out, but they were not always easy to find in the records, and were sometimes done by telephone, particularly at night. Independent multidisciplinary team reviews were not always easy to find in the records, but we did find evidence of external reviews taking place for patients who had been in long term segregation or seclusion for extended periods of time.

The medical director had carried out an audit of the use of seclusion in June 2017. This had found a number of areas for improvement, which included documentation of reviews and monitoring being limited or missing, seclusion care plans being absent or unrelated to positive behaviour support plans, and independent multidisciplinary team reviews of patients in seclusion not being carried out in keeping with the Mental Health Act Code of Practice. Following the audit staff had received additional training, and a pilot seclusion tracker was implemented in July and August 2017, which was due for review in September 2017. During our inspection we found that although checks were generally carried out, the information was not always easy to find.

The multidisciplinary management team discussed the use of seclusion and long term segregation at its daily meeting. They held a more detailed discussion of ongoing episodes of seclusion and long term segregation once a week, and this included identifying any patients who needed to be reviewed by an independent team, in accordance with the Mental Health Act Code of Practice. A reducing restrictive practice meeting was held once a month, which included reviewing the use of seclusion and long term segregation. A computer-based dashboard was used to monitor and analyse information about the use of restrictive interventions, and link this with interventions and de-escalation attempts, incidents and staff injuries.

Enhanced observations were regularly used across the hospital. At the time of our inspection there were 18 patients on one-to-one observations. The multidisciplinary team regularly reviewed the level of observation for each patient.

Medication was stored and administered correctly. Nurses completed daily checks of the clinic room to help ensure medicines including controlled drugs were stored safely. We looked at fifty-seven prescription charts across the hospital. The prescription charts were up-to-date and clearly presented to show the treatment people had received. Ninety-one per cent of 63 eligible staff had completed safe administration of medicines training. Nurses administered discretionary (non-prescribed) medicines for the prompt relief of minor ailments such as dry skin, when required. Patients were supported to use side-effect rating tools for reporting and monitoring side effects, so that they could be managed effectively. On the

low secure wards we saw that although patients did not have their own lockable storage, medicines self-administration was supported to promote patients' independence.

Staff told us that there had been problems with the supply of medication. Ten of the prescription charts we reviewed showed that stock had been missing of at least one medication on each chart. Three records showed that patients had missed doses of one of their physical health medicines for over a week due to a lack of stock. Three other records showed that patients had missed doses for managing hypersalivation, with one patient who had not received this for five days. Medication was supplied by an external pharmacy. The hospital had agreed a new service level agreement with a different company for the supply of medication and clinical pharmacist advice. The new contract was due to start on the 15 September 2017, and included weekly visits from a specialist mental health pharmacist with access to an electronic system for logging pharmacist interventions, to support learning and reduce supply problems.

Therapeutic drug monitoring was carried out and recorded where necessary. However, the hospital did not use dedicated charts for recording adjustments to the dose of clozapine (an antipsychotic medication), or for monitoring physical observations during clozapine treatment. Postural hypotension is a potential side effect of clozapine initiation but there were no records of this being specifically monitored. Two patients had not had all the recommended blood tests carried out before they started taking clozapine.

The service carried out an audit of the use of rapid tranquilisation in April 2017. They identified some gaps in recording patients' physical health monitoring after rapid tranquilisation. The service had developed an action plan to address this, but this was not yet fully implemented. We looked at records of 28 uses of rapid tranquillisation, and found incomplete or missing records of physical healthcare monitoring in 21 of the records.

The hospital's rapid tranquilisation policy did not reflect current National Institute for Health and Care Excellence guidance with regards to the medicines used for rapid tranquilisation.

Nursing staff had administered zuclopenthixol acetate (commonly known as acuphase), recorded this as rapid tranquilisation, and carried out vital signs monitoring of the patient afterwards. This medication is used for the short term management of symptoms and has sedating qualities, but does not have an immediate or 'rapid' sedating effect as is required for rapid tranquilisation. Nursing staff told us that they recorded zuclopenthixol acetate as rapid tranquilisation on the electronic records system. We discussed this with the medical director who confirmed that zuclopenthixol acetate had been prescribed and administered correctly, but agreed that it was not rapid tranquilisation.

The use of restrictions was reviewed on all the wards, and was discussed with patients in community meetings to explain why there were restrictions, and ask patients what they thought was reasonable. Self-harming behaviour was common in the hospital, so the restrictions varied from ward to ward. Staff were familiar with the concept of least restrictive practice, and the need to balance patient choice and positive risk taking with keeping people safe. Everyday items, such as crockery and pens, were restricted on some of the wards because they had regularly been used to self-harm, but this was reviewed and risk decisions were made on an individual patient and per ward basis. Where there were significant risks, alternatives were considered. For example, the use of pastry medication pots, chocolate spoons, and finger food.

The sleeping areas on the forensic wards were usually locked during the day, with set times when patients were able to go to their rooms. Staff told us this was to encourage patients to come out of their bedrooms and engage with activities. This was a blanket restriction, but it was reviewed by managers. Patients on the psychiatric intensive care unit had free access to their bedrooms at all times.

Eighty-nine per cent of staff (227 out of 256) were up to date with safeguarding of adults and children training. Eight-four percent of staff (215 out of 256) had completed Prevent awareness training. Prevent is a home office initiative, which aims to prevent vulnerable people being exploited for extremist or terrorist purposes. Staff knew how to identify and respond to potential safeguarding concerns. The social worker team led on safeguarding in the hospital, and were trained to an appropriate level. They provided training for other staff. Potential safeguarding concerns were discussed in the daily management meeting, and logged on a safeguarding tracker. If a concern was deemed to need referral to the local authority, this was carried out

by one of the social workers. Safeguarding referrals were made to the local social services team in Warrington, and the patient's home or lead commissioner was also informed.

The social work team co-ordinated child visiting to the hospital. Requests for visits were discussed and planned in a multidisciplinary team meeting. Visits from children were always agreed and arranged in advance, and supervised by staff. A similar process was followed for home visits by patients.

There were enough trained staff available to respond to a medical emergency. Qualified nurses and psychiatrists were required to complete immediate life support training, and other clinical staff were required to completed basic life support training. Ninety-percent of eligible staff (230 out of 255) had completed basic life support training, and 91% of eligible staff (68 out of 75) had completed immediate life support training. Staff had responded appropriately when medical emergencies had happened in the hospital.

Track record on safety

The provider had 34 incidents that met their criteria for serious incidents in the 12 months up to July 2017. This included incidents that occurred when the service was registered under a different provider. Of these incidents there were three deaths, 23 incidents that involved self-harm, three incidents that involved aggressive behaviour, and three incidents that involved unauthorised absence. The other incidents were a confidential information breach, and substance misuse by an inpatient. One of the incidents was an unexpected death following self-harm, and was the only serious incident that occurred on the psychiatric intensive care unit. The most frequently occurring serious incidents were ingestion or insertion of foreign objects, and self-harm.

We reviewed three serious incident reports, which included a 72-hour review and a root cause analysis. The level of detail in the reports varied, but overall they were completed satisfactorily. The reports showed that the incidents had been investigated and included the events leading up to the incident, possible triggers, and made recommendations for learning.

The service had made changes to the management of patients' belongings following a serious incident that involved a plastic bag. This included holding a 'decluttering' event with patients, to reduce the amount of unnecessary items in their rooms, and on the wards generally. Plastic bags were barred from the site, and patients were provided with fabric bags to use when shopping. Housekeeping staff became responsible for counting the supply of plastic bags needed for laundry.

Reporting incidents and learning from when things go wrong

The service had a computer-based incident recording system. Staff knew when to report incidents, and how to do this. Incident forms were automatically sent to the ward manager, lead nurse and hospital director, as well as other relevant staff such as the health and safety lead. Incidents were discussed and reviewed in the daily multidisciplinary team meeting.

Incident information was analysed and discussed as part of the service's governance system. For example, analysis of incidents showed an increase in incidents in the early evenings. Following this, evening activities were introduced and this showed a reduction in incidents during that time period.

Information from the incident recording system linked into the hospital's governance dashboard. From this, incident information could be analysed for individual patients. For example, recording the number of incidents they had been involved with which included including self-harm, restraint, and seclusion.

The service rated incidents by their level of seriousness. In the three months to 22 August 2017 there had been no level five incidents (severe, or most serious), four (0.3%) level four (high) incidents, 30 (2.1%) level three (moderate) incidents, 487 (34%) level two (low) incidents, and 889 (62%) level one (no harm) incidents. A further 23 incidents had yet to be categorised.

Staff told us that debriefs happened after serious incidents. The nature of this varied depending on the seriousness and type of incident, and the activity on the ward following an event. A psychotherapist was employed who provided work-related support to staff. This was implemented following a number of serious incidents and several assaults on staff.

Good

Forensic inpatient/secure wards

Staff received feedback about incidents by email, through supervision, or in team meetings/group sessions. The provider sent out a "lessons learned" newsletter to staff. Staff we spoke with were aware of the learning from recent serious incidents.

Duty of Candour

Health and care providers have a duty to be open and honest with patients and their families or carers when incidents occur, or mistakes have been made. This is called the duty of candour.

Staff received information about the duty of candour during their induction. Staff were clear about how they would respond to patients or their carers when incidents occurred. We saw examples of staff and managers being open with patients following serious incidents, and of responding to them appropriately. For example, following an incident the manager and medical director met with the patient, said they would keep her up to date, and wrote to her with information about the incident and the action that was being taken. Patients we spoke with said they were aware of action taken following incidents.

Information about the duty of candour was included in the summer 2017 carers' newsletter. We saw examples of the managers being open and sharing information with families following incidents.

Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We looked at 33 care records.

All patients had detailed assessments carried out after admission, and had care plans developed from this. The care plans were up to date, holistic and recovery focused. They included positive behavioural support plans, which were detailed and tailored to the individual. They gave clear information about events that may cause a patient to become distressed, and how staff should respond to this. However, the plans did not always explicitly include the views of the patient, or how involved the patient had wanted to be in the planning. A person-centred tool was used for care programme approach meetings, and this explicitly and clearly included the patient's views. Patients completed the tool before the meeting, and this ensured their views were incorporated into the development of their ongoing care. The tool showed how the patient's perception of their progress compared with the views of the staff.

Patients had their physical healthcare needs assessed and treated where necessary. A practice nurse and assistant were employed by the service, and provided screening and treatment for patients on site. A GP held routine surgeries each week, and there was a weekly physiotherapy session and access to a dietitian. Care records showed that the service had responded to patients' physical healthcare needs, and sought additional advice and support when required. For example, with regards to epilepsy, diabetes and continence. Patients received treatment and support for long term health conditions, such as diabetes and stoma care.

Patients' care and treatment was recorded in a computer-based patient record. Paper records were used for some information, such as recording physical healthcare observations.

Best practice in treatment and care

All patients were offered psychological and occupational therapy input. A range of psychological therapies was available in accordance with National Institute for Health and Care Excellence guidance. This included cognitive behavioural therapy for patients with psychosis, and dialectical behaviour therapy for patients with an emotionally unstable personality disorder. The service's dialectical behaviour therapy programme was in its early stages. Patients took part in a pre-treatment phase so that when they were ready they moved onto the full programme. The psychology team provided open sessions for patients, which included reviewing risks and tailoring psychological interventions to meet individual needs.

Patients had their physical healthcare needs assessed, and had access to screening, and monitoring and treatment for ongoing healthcare conditions. The service employed a practice nurse and assistant, and a GP provided routine surgeries at the hospital. When necessary patients were referred for specialist medical assessment and treatment.

Smoking was not allowed in the hospital or its grounds, and staff had received training in smoking cessation and the use of nicotine replacement therapies. Doctors made the appropriate checks for patients prescribed medicines that may be affected by smoking or nicotine.

English patients with a learning disability had had a care and treatment review carried out, in accordance with NHS England's commitment to transforming services for people with a learning disability or autism. The requirement for care and treatment reviews did not apply to the service's Welsh patients; however staff liaised regularly with Welsh commissioners.

The service used recognised rating scales to monitor health and outcomes for patients. This included the use of the Health of the Nation Outcome Scales, and evidence-based risk assessment tools. The occupational therapists used the Model of Human Occupation Screening Tool, and its related assessment tools, to assess patients' needs and monitor their progress. The psychologists used a variety of rating scales to determine changes in patient's mood and mental state.

The hospital completed internal audits of high dose antipsychotic prescribing. These audits showed an overall decrease in high dose prescribing over the last year. The hospital had submitted data to the Prescribing Observatory for Mental Health. This observatory collects data from participating organisations, and compares them. From this, organisations can benchmark themselves against similar organisations, and use this as a quality improvement tool. The results of the recent audit were due to completed by September 2017, so were not available at the time of our inspection.

Elysium Healthcare had an organisation-wide audit cycle, with specific audits for all inpatient services. This included medication prescribing, infection control, ligature audits and patient surveys. For example, in July 2017 the medical director led an audit of the use of rapid tranquilisation and seclusion. The hospital was implementing an action plan to address identified gaps.

Skilled staff to deliver care

Arbury Court had a multidisciplinary team of staff. This included occupational therapy, psychology and social work. The psychology team consisted of a lead psychologist, a senior psychologist and three other qualified psychologists, and a psychology assistant. The service was also providing a placement to a psychologist in training at the time of inspection. The occupational therapy team was made up of a lead occupational therapist and three other occupational therapists, and other members of the team which included an education facilitator and assistant, technical instructors and social activity leads. There were 2.6 vacancies in the department. The social work team included a lead social worker, two senior social workers, two further social workers and a student. The lead social worker post was vacant, but was temporarily covered by a lead from another service.

In the 12 months up to June 2017, most nursing staff and healthcare support workers were up to date with clinical supervision. The psychology and occupational therapy leads had management supervision with the hospital director, but did not get clinical supervision from a professional in their field. There were plans to arrange peer supervision with colleagues in other hospitals within Elysium. Most clinical and non-clinical staff had had an appraisal during the last 12 months.

All doctors in the service were up to date with their revalidation, which they must complete to remain registered to practice. Doctors had a weekly continuing professional development session, which included peer support and supervision.

The hospital provided staff with "reinforce appropriate, implode disruptive" or "RAID" training. This promotes a positive approach to working with people with aggressive or challenging behaviour, and is intended to be used by a whole team. Staff told us that the approach was helpful, but it was not always possible to implement effectively. This was due to a significant number of new staff working in the service, who had yet to complete the training. Training was planned for new staff.

Poor staff performance was addressed when necessary. Managers were supported by the human resources department to implement and monitor performance and disciplinary procedures.

Multi-disciplinary and inter-agency team work

The multidisciplinary team met each morning and briefly discussed all patients, and any concerns or developments within the service. Patients were discussed with dignity and respect, and the use of any restrictive interventions such as seclusion or restraint was reviewed.

A multidisciplinary meeting took place each week on all the wards, to discuss individual patients in more detail. Staff from all the professions attended the meeting, and relatives and care co-ordinators were invited. The meetings we observed took account of the views of the patient, and of each professional. The patient's wishes and potential risks were discussed openly and respectfully.

Patients were admitted from across the United Kingdom. The service had established relationships with commissioners of care, and worked with care coordinators from patients' local services.

The service had established links with the local authority in the area the hospital was situated.

Adherence to the MHA and the MHA Code of Practice

We did not carry out a Mental Health Act review of the service as part of this inspection. However, we reviewed Mental Health Act documentation and consent to treatment forms as part of our general records and medication checks.

The Mental Health Act documentation we reviewed was mostly in order. The service used a computer "dashboard" that that included a summary of information listed by patient and ward. This included Mental Health Act information such as the section of the Mental Health Act the patient was detained under, when their rights under the Act were last explained to them and when this was due again, and their consent to treatment status under the Act. The system highlighted when rights or consent were due or overdue.

The Mental Health Act contains specific requirements about the administration of medication to patients detained under the Act. Generally, if patients consent to take medication this must be documented, or if they refuse medication a second opinion must be obtained. These consent to treatment forms should be with the medication charts, so that nurses administering the medication know that they do so in accordance with the Mental Health Act. Ward Managers completed weekly checks to confirm that the relevant legal authorities for treatment were in place. The dashboard showed that three patients were highlighted as having their consent to treatment in need of review. However, we looked at 57 prescription charts and associated documentation, and found medicines prescribed on 13 prescription charts that were not included on the necessary Mental Health Act forms. Managers confirmed that errors were amended within a few days.

Patient records showed that patients had had their rights under the Mental Health Act explained to them. Most patients had their rights explained at least once every three months, but this was more frequent if required – for example weekly or monthly.

The service had a Mental Health Act administrator and assistant. The Mental Health Act administrator received detention papers during office hours, and carried out a detailed scrutiny of all Mental Health Act paperwork. Patients admitted into the forensic service were usually transferred from another hospital or prison, and this was pre-planned. Patients in the psychiatric intensive care unit may be admitted at short notice emergency, and this may be outside of office hours. Staff in the psychiatric intensive care unit received detention papers when the Mental Health Act administrators were not available.

An independent Mental Health Act advocate was based at Arbury Court.

Ninety per cent of 219 eligible staff had completed training on the Mental Health Act and Code of Practice. Staff we spoke with had a good understanding of the Mental Health Act.

Good practice in applying the MCA

All patients at Arbury Court were detained under the Mental Health Act. Some patients had a learning disability or other cognitive impairment, in addition to a mental illness. There had been no Deprivation of Liberty Safeguards applications.

Ninety per cent of 219 eligible staff had completed training on the Mental Capacity Act and Code of Practice. Staff had a good understanding of the principles of the Mental Capacity Act, and how these applied to the patients at Arbury Court.

Care records included an assessment of the patient's capacity. This was usually in relation to medication or specific treatment. There had been case formulations or best interest discussions for specific decisions. For example, in relation to surgery, or when patients were

prescribed medication for physical health conditions. The care records showed that attempts were made to provide the patient with information in a way that they could understand, and involved their families where necessary.

Patients had access to an independent Mental Capacity Act advocate when required.

Equality and Human Rights

Staff were required to complete equality and diversity training every three years. Ninety-seven per cent of 274 staff had completed equality, diversity and human rights training.

Are forensic inpatient/secure wards caring?

Good

Kindness, dignity, respect and support

We spoke with 31 patients, four carers or family members of patients, and received 10 comment cards. We also observed staff attitudes and behaviours when interacting with patients.

Patients were mostly positive about the staff and the service they received. They told us that their relationships with staff were supportive, friendly and relaxed. However, they told us that the wards were busy, and they felt there were not always enough staff. Leave and activities were sometimes cancelled because there were no staff available, but this did not happen often. The feedback from comment cards was positive. Patients were positive about staff who they found caring, were there when they needed them, and treated them with respect. The interactions we observed between staff and patients were friendly and respectful.

The most recent patient satisfaction survey was published in June 2017. It was based on the NHS Inpatient Mental Health Survey, and was completed by 52% of inpatients (37 patients) at the time of the survey. An action plan was to be discussed at the next governance meeting, for issues where over 25% of respondents gave a negative response. There were no key themes in the survey, as the responses were generally mixed. For example just over half of patients didn't think there were enough activities during the day, and just under half said the food was poor. Less than half of the respondents said they had had their rights explained to them in a way they understood, and over half said the hospital had helped them to keep in touch with their family or friends. About a third of respondents had talking therapies, and most found them helpful. Most patients who had physical healthcare problems said they had been given enough care for these. More than half of the respondents rated their care at Arbury Court as good or better, and under 3% rated is as poor.

Patients had differing experiences about how safe they felt on the wards. Some patients told us they felt safe, but others did not. Patients who did not feel safe told us this was mainly due to the behaviour of other patients, but was occasionally because they did not think there were enough staff available.

Patients on some of the wards were unhappy about restricted access to bedrooms during the day. The level of restriction varied from ward to ward. All patients were limited to 14 snacks per week, but were generally accepting of this.

The involvement of people in the care they receive

The service aimed to have at least one patient representative from each of the wards. At the time of our inspection this was the case on all but Delamere ward. Staff told us that this was because none of the patients were currently well enough or wished to take on this role. Patient representatives were part of the Patients' Council.

Patients' Council meetings were attended by patient representatives, and by staff who could make decisions and changes within the hospital. This regularly included the hospital director, complaints officer and recovery coordinator, and as necessary the leads for housekeeping, maintenance, nursing, occupational therapy and social work. The meetings demonstrated positive patient involvement, and all issues raised were taken seriously and acted upon. Issues raised in the patients' council meetings were fed through in to the clinical governance meetings. Patients were given an explanation when things could not be resolved. The concerns identified and issues discussed were varied, and over time ranged from increased disturbance on the wards, garden access, and occupational therapy input, to information about CQC inspections and the corporate audit cycle.

Patients were supported by the recovery worker to attend and participate in clinical governance meetings. Patients' representatives also attended the meetings to review

commissioning for quality and innovation national goals, which were set by commissioners. This included the commissioning for quality and innovation targets for least restrictive practices, where a task list was produced to take actions forward. This included actions for patient representatives, for example they were to present at staff training sessions.

Patients were involved in staff recruitment, and participated in staff interviews as part of a "real work" initiative. They were paid a small amount for this. Two former patients also presented at staff inductions, and discussed their recovery journey through Arbury Court.

Following a serious incident, the service had identified the need to reduce the volume of unnecessary items in patient's rooms, and in communal areas of the wards. The manager wanted to engage patients in this activity and make it enjoyable, rather than staff simply removing patients' belongings. They introduced a programme called 'clutterbug' where staff and patients decluttered their rooms, and disposed of or voluntarily donated items they no longer needed to charity. The service has held a number of events, where staff and patients worked together to raise money for charity. This had included a cultural market, and the Arbury choir.

Records showed that patients had been offered copies of their care plans, except where there were restrictions on paper being on the ward because of risk. The patients we spoke with had mixed views about how involved they were in their care planning.

'Pathnav' was a person-centred template that recorded both patient and staff views, and monitored patient's progress. This had replaced the previous care programme approach document. The recovery worker supported patients to plan their own care programme approach meeting and ensure that their voices and needs were heard, and they were involved in their care. Patients were supported to chair their care programme approach meeting if they wished, and staff told us there had been four patients in the previous 12 months who had chaired their own CPA meeting. Pathnav was not used in the psychiatric intensive care unit. The multidisciplinary meetings we observed were positive, involved the patient and treated them with respect. The patient's views were listened to, and any risks or concerns were discussed. Patients were supported to prepare for the meeting, so that they were able to make requests and voice their opinions.

The carers we spoke with were mostly positive about the service, and the communication with and about their relative. The service had responded when complaints or concerns had been raised. There was a carers group, which provided information about care and mental health conditions, and was an opportunity for carers to meet other families. Carers were provided with information about the service. This included a welcome pack with practical information about what to expect in the service, and visiting and contact arrangements. The social workers led on contacting carers and relatives, and co-ordinating visits. Staff told us that it could be difficult to coordinate groups for carers, because patients were admitted from all over the United Kingdom. A carers' forum was planned for October 2017 to try and involve carers.

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

Good

Access and discharge

Patients were admitted from across the United Kingdom which included England, Wales and Northern Ireland. NHS England commissioned beds for forensic patients living in England. Local health commissioning bodies commissioned beds for patients from other countries in the United Kingdom. The average number of days from referral to initial assessment for the forensic wards ranged from two to nine days, and from initial assessment to onset of treatment from 13 to 26 days. The service did not have a waiting list. The average length of stay on the forensic wards, up to the 4 July 2017, ranged from 557 days on Oakmere ward to 1003 days on Delamere ward. The average bed occupancy of the forensic wards, in the six months up to 30 June 2017, ranged from 93% on Appleton and Oakmere wards, to 99% on Delamere ward.

Psychiatric intensive care beds (Primrose ward) were commissioned by individual trusts/commissioners across the United Kingdom. Referrals were sent directly to the ward, and the initial assessment for the psychiatric intensive care unit usually took place on the same day as

the referral. If accepted a patient would, on average, usually be transferred on the same day. The average length of stay on Primrose ward was 34 days. The average bed occupancy, in the six months up to 30 June 2017, was 59%.

Patients were only moved between wards for clinical or safeguarding reasons. Patients on the forensic wards required commissioner approval before they were transferred to a ward with a higher or lower level of security. Patients on the psychiatric intensive care unit were not moved to other parts of the service.

In the six months up to 30 June 2017, the service had two patients who met the criteria for a "delayed discharge". They were waiting for beds in a hospital with a higher level of security. Both patients had been assessed by other services, who made no further recommendations for their care and management at Arbury Court. The service was actively involved in identifying more suitable placements for patients.

Patients on the forensic wards had a care programme approach meeting to discuss their discharge arrangements every six months. The service used 'pathnav', which was a person-centred template that recorded both patient and staff views, and monitored patient's progress. This was completed with the patient prior to the care programme approach meeting. Care programme approach meeting notes were recorded during the meeting, so could be sent out to the people involved straight afterwards.

The facilities promote recovery, comfort, dignity and confidentiality

Each ward had a lounge area with a television, meeting rooms, a quiet room and access to outdoor space. Access to some facilities depended on the ward and individual risk assessments. Shared communal areas between wards provided patients with additional space for activities and to socialise with other patients. There were dedicated rooms for hairdressing and beauty treatments, a gym, and for physical healthcare checks or GP appointments. Patients had an onsite shop, where they could buy snacks and toiletries, and a small range of other items such as clothing and gifts. There was access to secure outdoor space from each of the wards. This was restricted or open depending on the ward, but was always observed by staff. Following a period of extension and refurbishment work the former footpaths and landscaping around the site had been reduced. Plans were in place to re-landscape the outdoor space in the following spring and summer.

Arbury Court only provided services to female patients. All patients had their own bedroom with ensuite facilities. Patients were able to personalise their rooms, subject to risk assessment. There was lockable storage in each patient's room. Patient access to this was risk assessed. Patients on some of the low secure wards had their own key.

There was a payphone on each of the wards. Patients had access to their own mobile phones, but this was restricted on some of the wards. Patients were not allowed to use smartphones in the hospital, but they may be allowed to use them if they went outside the hospital, following a risk assessment. Visiting' rooms were in each of the buildings, and had toys available for child visitors. Social workers led on coordinating visits and liaising with families.

The hospital's catering team cooked food on site. There was a rolling menu, with healthy eating choices. Halal food and other special diets were available when required. Many of the patients we spoke with said they did not like the food, so a food group had been set up to address this. All wards had tea and coffee making facilities, but access to this was limited on most of the wards based on risk assessment. There was open access to the kitchen on Heathfield ward. Drinking water was available, and staff made patients tea and coffee on request. Patients had their own snacks, with a limit of 14 snacks per week, but they could have these when they wished up to this limit. The limit had been agreed following discussion with patients through ward meetings and the patients' council. It aimed to balance healthy eating and patient choice.

Each ward had an activity programme, with access to activities seven days a week. The activity programme was led by the occupational therapists, with other activities provided by nurses and healthcare support workers. Activities were available for individuals, or designated groups of patients. All patients had access to at least 25 hours of activity per week. This was recorded and monitored through the hospital's 'dashboard', which showed that patients had participated in activities throughout the week. Staff supported patients to engage in activities, adapting them where necessary if a patient had been aggressive or self-harmed. Onsite activities included

access to the gym, watching films, playing pool, baking, arts and crafts, gardening, board games, and pamper sessions. Women could book hair and beauty sessions in the onsite salon. Staff had set up a slimming club for patients. Activities were arranged outside the hospital for patients who had leave. This included going to restaurants, the theatre, shopping and the seaside. Patients were supported to visit their families and go on home visits where possible. The service had organised events with patients to raise money for charity. Patients gave mixed feedback about the benefit of the activities available – some were very positive, others were not interested or found them boring.

There was a real work programme, where patients were supported and paid a small amount to work in the shop, café and carry out domestic duties. The café club was held in the area between the wards, so that patients from three of the forensic wards could attend and socialise with one another. This was co-hosted by an occupational therapist and a patient.

The service had a recovery college, and carried out an evaluation of this in August 2017. This acknowledged that the college was still in its infancy, but identified areas where it needed to develop, and courses that patients were interested in. There was a plan to take this forward, and the next term was due to start in September 2017.

Meeting the needs of all people who use the service

When patients had specific needs, the service adapted to meet these. For example, rooms had been adapted, and edible medicine pots were provided to meet a patient's needs. There were supported bathrooms in patient areas across the site, and a disabled toilet was available for visitors. Some patients had electronic scooters for use outside the building.

There was information available for patients about the service which included activities, how to make a complaint, safeguarding, restrictive practice, and advocacy. All patients in the service at the time of our inspection spoke English. Some patients spoke Welsh as their first language, and there were some signs and written information available in Welsh. Information about the Mental Health Act was available on the internet, and could be downloaded in many different languages including Welsh. Information about the Mental Health Act was also available in an easy to read format. Staff told us interpreters were available when required.

Patients with a learning disability had had a care and treatment review completed, with the information present in easy read format. This included topics such as all about me", 'health passport" and "keeping me safe". The care and treatment reviews were written from the patients' point of view and included a positive behaviour support plan. This included information for staff on when a patient may need extra support, what may help to prevent them becoming distressed, and what action to take following any incidents.

Patients could use the multi-faith room in the hospital. Staff told us that religious leaders visited when requested. Patients with special dietary requirement were catered for. This included, for example, halal or vegetarian food, although patients told us the choice of options was limited.

Listening to and learning from concerns and complaints

The hospital received 80 complaints in the last 12 months, and 38 of these were upheld. No complaints had been referred to the Parliamentary and Health Service Ombudsman.

Patients knew how to raise concerns or make a complaint. Information about how to make a complaint was displayed on noticeboards throughout the hospital, and provided to patients in welcome packs on their arrival. Patients also raised complaints directly with staff, or at community meetings. Community meetings took place on all the wards. These included discussion of concerns and ward-related issues. Staff on the psychiatric intensive care unit told us that they held community meetings when possible, but patients were often too unwell to attend. The hospital had a complaints officer who coordinated and supported patients with their complaints. Patients knew how to contact the complaints' officer and the independent advocate, and were generally positive about the support they received with complaints.

Each month, a summary of the complaints received and the actions taken were documented so that trends could be identified, monitored and acted on effectively. Patients most commonly complained about staff shortages, the behaviour of other patients, and staff attitude. The service had identified these trends and put together action plans

to address these. The last inspection identified a trend of complaints of property going missing or being damaged. Action plans were put in place and this trend of complaints had lowered. The Patients' Council, attended by patient representatives from each of the wards, reviewed complaints information at their monthly meeting.

Staff knew the hospital's complaints procedure, and how to access it on the hospital's intranet. The procedure listed six key principles to be adhered to when handling complaints. These were: getting it right, being customer focused, being open and accountable, acting fairly and proportionately, putting things right and seeking continuous improvement. We reviewed a sample of three complaints that had been submitted within the last 12 months. These showed that the complaints process had been followed correctly and the six principles applied. Complainants were given information about the next steps of the complaints process, and supported to get an advocate.

Are forensic inpatient/secure wards well-led?

Outstanding ☆

Vision and values

Elysium Healthcare's values were: innovation to drive forward the standards and outcomes of care; empowerment to encourage all to lead a meaningful life; collaboration so that in partnership they can deliver transformational care; integrity to be ethical, open, honest and transparent; and compassion to show respect, consideration and afford dignity to all. The values were on display, and reflected in the interactions and records we saw during our inspection. These values were displayed during our inspection.

Good governance

The Elysium Healthcare board delegated clinical governance at a national level to the corporate clinical governance group. This was attended by the medical director and hospital director from Arbury Court. From this there were regional and hospital-based operational governance groups that met monthly. The hospital governance group met monthly and monitored progress against six objectives: communication; enhanced observations and risk management; recruitment and retention; staff morale; work smarter not harder; training and induction. They did this by reviewing policies, key performance indicators, incidents, complaints, alerts and medication issues, staffing including recruitment, training and appraisal, and audits. Patient representatives from the Patients' Council led part of the meeting that discussed patients and carers' experience. Issues raised in Patients' Council meeting fed into the monthly clinical governance meeting. Minutes from the governance meetings showed that the meetings were well attended and included at least one patient representative. From each meeting, there were clearly identified actions with a person responsible and timescales, and this was followed through at subsequent meetings.

The service used a computer-based 'dashboard' to monitor and summarise key information about patients. This was used to monitor the care of individual patients, and to summarise how wards and the service overall was performing. The information was extensive and ranged from the number of contacts with different professionals, meaningful activities attended, when care plans and assessment tools were last reviewed and next due for review; physical healthcare checks, and Mental Health Act information such as rights and consent to treatment. Information about incidents, restraints, and seclusion was also recorded. Reports for each of the wards showed that they were meeting most of the standards. Where there were gaps, these were recent, and ward managers provided an explanation and the action that was being taken to address it.

The dashboard was accessible to ward managers, and impacted on individual patients' care. For example, if a patient had not had physical healthcare checks carried out, or if they were not having the required amount of meaningful activity, this was highlighted on the dashboard, and action was taken to address it. The dashboard could show an individual patient's progress over any specified time period. For example, a sustained reduction in the number of incidents or restraints a patient has been involved in, or an increase in engagement with meaningful activities. A managers' meeting took place every weekday morning, attended by the multidisciplinary team, so that they were aware of what was happening across the hospital. The same group met weekly to review performance. This included reviewing the dashboard indicators for 25 key measurements for each patient.

Good

Forensic inpatient/secure wards

Under each of the main sections of the dashboard additional information could be found. For example, within the complaints section of the dashboard, in addition to the number of complaints and timescales, but one could easily see which had involved a safeguarding concern, or where there were uncompleted recommendations from the complaints. The reducing restrictive practice section of the dashboard included a detailed breakdown of the numbers of restraints, seclusion, long term segregation and injuries. Analysis of this information included times of day, duration and which part of the body had been held. The information could be analysed in multiple ways. For example, by individual patient, at ward level, by type of event, or duration. This information was used to inform the key performance indicators that were reported to commissioners.

Commissioners reviewed patients and/or met with managers regularly. The service submitted monitoring information to the commissioners, with different information being provided depending on the commissioning body. All forensic patients from England were commissioned by NHS England. Through NHS England the service was required to complete commissioning for quality and innovation national goals. Arbury Court had commissioning for quality and innovation goals for recovery, which was led by the occupational therapy department.

Arbury Court was in the second year of commissioning for quality and innovation national goals to reduce restrictive practice, which included the use of restraint, seclusion, rapid tranquilisation and long term segregation. Arbury Court had implemented a governance and implementation plan for reducing restrictive interventions and practices. It had an agreed target with its commissioners to do this, so collected information about the use of restrictive practice, reviewed these, and reported the outcome to the commissioners of its services. Incidents were reported and reviewed at a local level, and escalated through the hospital's governance structure. The plan contained interventions and outcomes known to reduce incidents, such as therapies and training, and specific outcomes to measure success – such as reduced numbers of seclusion, long term segregation, restraint, staff and patient injuries, and patient complaints in relation to restrictions. The psychiatric intensive care unit was not subject to the commissioning for quality and innovation targets, but was included in the collection of information and strategies to decrease the use of restrictive interventions.

The service had a risk register. This included guidance for assessing the level of risk, and the likelihood of its occurrence. The manager of Arbury Court was able to add items to the risk register. Each of the potential risks identified had measures in place that mitigated against it. The types of potential risks identified were in the areas of patient related harm, operational concerns such as staffing, practical concerns such as problems with the building or facilities, and financial/commissioning difficulties.

National alerts and safety information were reviewed by the manager with other members of team. They decided if the alert was relevant to Arbury Court, and if action was required.

Leadership, morale and staff engagement

The staff we spoke with were mostly positive about working in the service. They told us that the wards were very busy, and patients had very complex needs and behaviours, and working with this could be difficult, particularly if there were not enough permanent or experienced staff available. However, they did feel supported by their colleagues, managers and senior managers. Staff were positive about their managers and senior managers in the unit, who were visible on the wards, and whom they found supportive and responsive to their concerns. Staff from all the professions told us they felt supported within the service, and worked well with other members of the multidisciplinary team. They felt they had a voice as individuals, and as their profession such as nursing or social work.

Staff told us they felt able to raise concerns and that they were listened to. Staff were positive about the support they received from managers within the hospital. Analysis of incidents had found an increase in incidents in the evenings, which was when there were generally fewer senior staff available. In response, a senior nurse was scheduled to be on site from at least seven-thirty in the morning, to nine o'clock in the evening.

A psychotherapist provided support to staff with work-based problems. The psychotherapist worked with the employee engagement lead, whose role was to support and work with staff.

The employee engagement lead's role included identifying staff concerns, carrying out exit interviews, and liaising with staff who were suspended or subject to a disciplinary procedures.

The hospital director of Arbury Court was the registered manager of a sister hospital, following the appointment of a new manager there. The hospital director worked mostly at Arbury Court, and had applied to be the registered manager there, and was successfully appointed after the inspection. The hospital director was enthusiastic and innovative in responding to issues within the hospital and developing the service. For example, initiatives had been implemented that involved staff and patients in developing the service. This included a 'clutterbug ball' after a decluttering and tidying exercise, and an Alice in Wonderland-themed governance meeting aimed to encourage staff engagement.

The service had a sickness target of 3% which they had achieved. The sickness rate at Arbury Court over the last year was 1.7%.

A staff survey was last carried out in March 2017. This showed an overall improvement in staff morale, but highlighted that there had been an increase in aggression towards staff, that the wards were very busy and under pressure because of staffing, and potential issues around staff development. Managers told us that they had responded to this by listening to staff, working to improve recruitment processes, and being visible. Staff were provided with a book of benefits of working for Elysium, and had access to an external helpline for counselling and support. A 'safer place to be and work' group was set up following an increase in aggression and assaults on staff. A psychotherapist was brought in to provide regular support to staff, to discuss work related issues, following a number of serious incidents and assaults on staff.

Elysium Healthcare had human resources policies that applied to staff at all its services. Each ward manager was provided with detailed staffing information, to support their management of staff on their ward. Ward managers received advice and support to manage sickness, performance and any staff disciplinary actions. Elysium Healthcare had an overarching policy and campaign for recruitment of staff. Arbury Court had its own recruitment strategy, to meet its specific staffing and recruitment needs and challenges.

Each ward had a ward administrator. Administration staff supported other activities within the hospital which included human resources, the Mental Health Act, and the care programme approach.

Commitment to quality improvement and innovation

Arbury Court was part of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services for its medium and low secure wards. Services registered to be part of the network, and peer assessments were carried out by other professionals within the network. Arbury Court was last reviewed by the network in October 2016 when it was registered under a different provider. It met 78% of the medium secure standards, and 75% of the low secure standards. The report noted that improvements had been made since the previous review. Arbury Court produced an action plan to address areas where it was deemed to not be fully meeting the standards set. The next peer review is due to take place in October 2017.

The ward manager of the psychiatric intensive care unit (Primrose ward) was registered with the National Association of Psychiatric Intensive Care and Low Secure Units, though the unit itself was not. The National Association of Psychiatric Intensive Care and Low Secure Units is produces guidance for and promotes development within psychiatric intensive care and low secure units.

Medical staff carried out prescribing audits using the tools provided by the Prescribing Observatory for Mental Health. This included audits of the use of high dose antipsychotic medication.

Outstanding practice and areas for improvement

Outstanding practice

The service used 'pathnav', which was a person-centred template that recorded both patient and staff views, and monitored patients' progress. This was completed with the patient prior to the care programme approach meeting, and ensured they were involved in their discharge planning.

Patients were involved in the development of the service. This included patient representatives forming the Patients' Council, and being part of the clinical governance meetings.

A computer-based dashboard was used to collate information about patients, and this was monitored and used to inform patient care. This included a range of information from care plans, activities and physical health checks, to the detailed information about the use of restraint and seclusion.

Staff had access to support from a psychotherapist to address work related issues. This was seen to be of particularly benefit following serious incidents, and assaults on staff.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that prescribed medication, including for physical healthcare conditions, is available for patients.
- The provider must ensure that the correct monitoring of patients is carried out and recorded for patients receiving clozapine, and after rapid tranquilisation.

Action the provider SHOULD take to improve

- The provider should ensure that the rapid tranquilisation policy is consistent with current guidance, that staff have a clear understanding of rapid tranquilisation, and that the use of rapid tranquilisation is recorded appropriately.
- The provider should ensure that medication is administered in accordance with the Mental Health Act Code of Practice, and included on the appropriate consent to treatment form.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There were occasions when medication was out of stock for physical healthcare medication which led to doses being missed. Monitoring of patients after rapid tranquilisation was not always carried out or recorded in patients' records. **This was in breach of regulation 12(1)(2)(a)(b)(f)**